2/09/12 PRESENTATIONS: OFFICE OF CHILDREN'S SERVICES & ALASKA TRIBAL HEALTH CONSORTIUM

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2011

OCS Response to CRP Annual Report

State of Alaska

Department of Health & Social Services

Office of Children's Services

Executive Summary

On behalf of the Department of Health and Social Services, Office of Children's Services (OCS), I want to thank you for your time and efforts during this past year. I recognize the volunteer hours and dedication that your membership requires and value your many efforts to impact positive growth and change for this agency. Through your many site visits, OCS staff have undoubtedly shown you how dedicated and wonderful they are as well.

The agency's vision of *safe children, strong families* can only be achieved through the dedication and commitment of the roughly 500 employees that come to work every day to do the best job they possibly can. The hardworking OCS staff deserve recognition for the contributions they make to help keep children safe, families strong, and in keeping the agency operations running smoothly day after day.

The Citizen Review Panel (CRP) provides valuable insight, information, and recommendations to the agency and to me as the Director. This past year has been filled with many successes and of course some new and ongoing challenges. I have appreciated all of the feedback you have provided to me via your contacts with staff, community, and others who have contact with OCS. In particular, I found the joint site visit to the Bethel community particularly beneficial as it allowed me to hear the issues first hand and be better equipped to follow up on issues raised.

After reviewing the OCS response to your recommendations, please don't hesitate to contact me so that I may clarify or provide additional information to the panel. I look forward to another year of productive partnership.

CHRISTY LAWTON, DIRECTOR

CRP Recommendation 1:

Based on our recent site visits to the Fairbanks and Wasilla field offices, we recommend that OCS work to improve the culture within the agency. The current atmosphere impairs the ability of workers to appropriately protect Alaska's children and families.

OCS Response:

We recognize the important contributions made by all OCS employees and strive to foster a collegial, positive and collaborative work environment. There are times however when pockets of staff within offices or offices as a whole are feeling particularly overwhelmed and frustrated. The culture within offices is often heavily influenced by the leadership within them. Leadership being long term front line staff as well as supervisors or managers. The positive or negative energy can ebb and flow, sometimes being influenced by as few as one disgruntled employee that impacts everyone around them. Office dynamics are challenging. We recognize that stress is inherent in this work and that in can play out in many ways with our employees. We encounter just as many employees who say they are leaving the agency because of the internal culture as we do who say they are staying because the culture of support, teamwork, and camaraderie is so positive.

In recent months, we have been trying some new approaches to involve OCS employees in fostering a more collegial and overall more positive work environment. These include soliciting feedback from employees, involving more employees in decision making, and modifying the way we share internal information.

Soliciting feedback from employees. We continue to modify and improve our annual employee survey. This year we had 317 responses representing 74% of our staff. Among the many things we learned from the survey:

- 79% agree or strongly agree that the philosophy of the Office of Children's Services as reflected in the Practice Model is clearly described to staff.
- 77% agree or strongly agree that they receive feedback from their supervisor regarding their performance which is useful in making changes in their work.
- 84% agree or strongly agree that their supervisor is available and responsive to questions they have regarding their work.

However, we also learned that only 42% of respondents agreed or strongly agreed that there are regular opportunities to provide information and suggestions to regional and state office management. For this reason, we are committed to continue working to improve opportunities for open communication between all employees of the organization.

Modifying the way we share internal information. Based upon feedback from OCS employees, our internal newsletter will be undergoing a major overhaul in 2012. Among the many changes, the name of the newsletter will be changed from "The Pipeline" to

"Frontline" to reflect our focus on the importance of our employees on the front line of child protection. In addition, the content will be modified to include all levels of staff from across the state, and focus more on positive events, self care tips, humor, and photos rather than strictly programmatic information sharing from management to field staff. All employees will be encouraged to submit topics and articles for Frontline.

Involving more employees in decision making. In recent months, the Wasilla field office has developed and started implementing a plan of improvement. This process was designed with the help of external facilitators who engaged local staff in problem solving and strategy development. This process has been very effective and by their reports, found to be useful and beneficial by all level of employees who participated including front line workers, supervisors, managers and administrators. We intend to continue using these types of inclusive methods to involve all levels in decision making whenever possible.

In addition, we are currently soliciting volunteers to participate in a formal *statewide* Employee Advisory Committee. Beginning in 2012, we intend for this committee to represent the interests of our front line staff and to have a regular and consistent forum to express their interests through direct discussion with the Director and senior leadership staff.

CRP Recommendation 2:

That OCS revisits the idea of regional intake and continues to evaluate its effectiveness.

OCS Response

The decision to move towards regionalized intake was made in large part based on the findings of the Child, Family, and Services Review (CFSR) conducted by the Children's Bureau in 2008. It was clearly identified in this review as well as OCS's reviews previously, that Protective Service Reports (PSR's) were not being initiated timely. The CFSR measures states in the areas of safety, permanency, and well being. Safety Outcome 1 looks to ensure that children are, first and foremost, protected from abuse and neglect. One item measure within this outcome measures the timeliness of initiation which looks at whether the assigned worker made face to face contact with the alleged victim within the priority response time. OCS recognized that one of primary reasons we were failing to meet the standard set for this item is that PSR's were taking too long to come out of intake and get into the assigned worker's hands. If a report for example is screened in as a P2 which dictates a face to face contact within 72-hours, that clock begins to run as soon as intake receives the call, not when the worker gets the actual assignment. So, if the PSR sits in intake due to any number of delays, the worker may already be out of compliance by the time they receive the report.

The lack of standardization and unique structure of OCS's 26 field offices was not conducive to the intake function being done efficiently enough to ensure child safety. This coupled with our recognition of the varied degrees of skills, job class, and office size that were handling intake reports really supported the idea that a major change needed to occur in order to see improvement.

That being said, there has been a significant amount of work done in the area of regionalizing intake in the last several years, most notably during 2011. While the road has not been entirely smooth, OCS feels we have made the right decision by regionalizing the intake process. To ensure that regional intake continues to make the needed progress, each of the regional intake offices is making training and community outreach a priority to local cities and villages. In addition, OCS is gathering data monthly in order to monitor data trends and how consistent we are being to our practice model. The use of data is invaluable to this process and helps to distinguish fact from fiction. For example, some in the Northern region were concerned regionalized intake were result in a decrease of reports being made because some locals would not call Fairbanks to make a report. The data overall however, indicates the opposite. Since regionalizing intake in NRO, the number of reports has increased incrementally since implementation began.

The Northern Region (NRO) and South East Region (SERO) have been active in educating and proactive in the communication regarding our new intake process with community providers, Tribes and OCS staff. The South Central Region (SCRO) has just begun working to provide training and education of community providers, tribes, and staff members. Most recently, NRO, SERO, and SCRO have received new outreach materials. These materials are newly designed business cards and posters that have the toll-free number for their regional office; and also have a bar code that can be scanned with a smart phone. The smart phone reads the bar code, and depending on which bar code scanned it leads to the specific regional phone number or the regional intake email box. Although we are striving to make all local concerns come through our regional intake offices, we recognize that there are still some community members that would rather make a report in their local office. We have worked with our local staff to assist in gathering the information and calling the regional intake worker together to try to bridge the gap of hesitancy of reporting to someone out of their area.

In addition to the outreach materials, OCS is conducting trainings through on-site visits in many of the rural communities as well as to those in the regional office location. Many of the regional intake offices are making frequent monthly telephone contact with the key stakeholders and reporters in the region. It is of vital importance to OCS to meet and alleviate any problems or concerns in the smaller communities, perceived or real. One of the ways OCS recently evaluated effectiveness was by completing a survey of stakeholders and OCS staff. The purpose of the survey was to accurately identify where things are going well and what needs are identified so we can make mid-course corrections if necessary. The survey was conducted in the Northern and Southeastern

Regions in August 2011 with follow-up to those who had not responded in early September. The survey was conducted electronically. The survey was sent to 131 community members with 59 respondents. The survey was sent to 83 OCS staff with 53 respondents.

The survey addressed the general experiences staff and community members had with the regional intake process. Areas such as how well they understood the intake process and how well they believed the process was working were explored. Responses were mixed and a summary of some of the responses are presented below.

According to survey results, community members generally indicated their calls were returned in a timely manner when they had to leave a message with 43 percent indicating the response was timely and 19 percent that the response was not timely. A large number, 71 percent, indicated they knew who to contact after hours. Community members generally did not agree that the Office of Children's Services was more responsive as a result of regional intake with only 16 percent agreeing and 34 percent disagreeing. Similarly, community members felt that timely feedback was an area for improvement with 44 percent indicating they did not receive timely feedback.

A little over 75 percent of staff, who responded, believed maltreatment concerns are received and documented in a timely manner since implementation of regional intake. Similarly, 82 percent believed they had a clear understanding of the roles, tasks, and responsibilities of intake staff. Staff indicated, 51 percent, which they had heard from community members that there was uncertainty in the community on who to make a report to after regular business hours.

In order to continue to monitor and receive feedback on the implementation of regional intake, OCS will survey community members and staff again in March 2012. This process will provide information on which to make adjustments to the program where needed and training to staff as indicated.

OCS has had many discussions regarding regional intake taking all calls after hours and on weekends. Due to budget consideration and staffing levels it is not possible to the regional intake staff to handle all after hours and weekend calls for their entire region. However, we are interested in more fully exploring the options and need in the future, but feel the focus for now, needs to remain on continued implementation of regionalized intake such that we are hitting the mark in all five regions and have streamlined the process to work at a premium for both stakeholders and staff. To expand and grow the program now would dilute our efforts here and spread us entirely too thin to accomplish our current goals.

Every region now has its own toll free 800 number. We are working on sharing this information with the local areas as well as updating the OCS web site to reflect the regional intake toll free numbers and email addresses. We have also been reviewing the afterhours and weekend practices that offices are using statewide with goal of improving

customer service and creating more uniformity. For the offices with answering services we are doing a thorough review of the contract to include what instruction they are given in an effort to ensure that they are not making any decisions or judgment calls, that are strictly agency ones. We are also setting up random calls to inspect their response to ensure appropriateness of answering service.

In summary, while we recognize there is more work to do to streamline and standardize our processes so that intake operates effectively, we believe it is the best strategy for Alaska and are committed to its continued implementation and development.

CRP Recommendation 3:

Improve compliance with court obligations.

OCS Response:

We recognize the importance of obtaining reasonable and active efforts findings in court as it indicates that OCS has met its obligation to provide adequate efforts to prevent the breakup of families while ensuring child safety. The importance of these findings cannot be overemphasized and it should be noted that OCS meets its obligation in the vast majority of cases.

As indicated in the CRP report, the Wasilla field office has been struggling on many levels for quite some time. While there has been very good work occurring with some families and stakeholders, others have reported very negative experiences.

During 2011, numerous efforts were made to improve services. In February, four new front line employees were moved to Wasilla to reduce the workload of existing employees. In July, key priorities for staff were identified to ensure clarity of focus. In September and October, members of the office participated in a planning process to develop problem solving strategies focused on overall responsiveness to clients and members of the community, timeliness of documentation (including court reports and ORCA input), the increase in the number of children in out of home placement, and the completion of caseworker visits with children and families. The resulting plan is currently being executed and we expect to see positive results in the coming weeks and months.

While many efforts were made during 2011, we expect further progress in 2012 and beyond. While our current efforts will continue, we also intend to engage families and community stakeholders in collaborative problem solving provide training and development opportunities for OCS employees, ensure balance of workload commensurate to other field offices, and help foster a philosophy of continuous quality improvement.

CRP Recommendation 4:

That OCS improves the prominence of the telephone number to report abuse in telephone book.

OCS Response

Since the concern of the CRP regarding the location and prominence, or lack thereof, was brought to the agency's attention we have reviewed the listings statewide. Each region reviewed the major phone books or publications used by the community to ensure that the OCS numbers were listed in a clear and prominent location.

All of these publications have since been updated and/or are in the queue to be based on the publisher's regular schedule. We believe this issue is fully addressed and that any person seeking our number or services should easily be able to locate our listing.

Representative Bob Herron

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House District 38
Kuskokwim & Johnson Rivers
Kuskokwim Bay & Nelson Island

Akiachak
Akiak
Atmautluak
Bethel
Chefornak
Eek
Goodnews Bay
Kasigluk
Kipnuk
Kongiganak
Kwethluk
Kwigillingok
Lower Kalskag
Mekoryuk
Mertarvik
Napakiak
Napaskiak
Newtok
Nightmute
Nunapitchuk
Oscarville
Platinum
Quinhagak
Toksook Bay
Tuluksak
Tununak
Tuntutuliak
Upper Kalskag

February 9, 2012

Christy Lawton
Director, Office of Children's Services
3025 Clinton Drive
Juneau, AK 99801

Via email: Christy.Lawton@alaska.gov

Christy,

It has been good to hear from yourself and others this week about OCS and foster care in Alaska. This letter lists are the OCS-specific questions to which I referred in our 2/7/2012 House Health and Social Services meeting, as well as some that were originally intended for the Citizen Review Panel but I believe you also can shed light upon. In no particular order of importance:

1. Raised Tuesday evening - CRP 2011 Recommendation #1 to OCS (pg.11) reads: *"... we recommend that OCS work to improve the culture within the agency. The current atmosphere impairs the ability of workers to appropriately protect Alaska's children and families."* The narrative continues: *"When asked about desired working relationships with partnering agencies OCS spoke of a desire to collaborate. Yet OCS does not collaborate with its own staff when it comes to changing policies and procedures... new policies or programs are handed down without them having an adequate opportunity to provide input. At present they are not asked the right question in order to generate input – for example, they are offered an opportunity to wordsmith the policy without being asked about its impact. The assumption has already been made that the new initiative will be implemented; they can just weight on the 'how,' NOT the 'if.' We suggest that OCS leadership respect the enormous knowledge base of workers enough to ask them 'if' a new policy or procedure is a good idea and whether it would work well in their unique region of the state."* Moving further to pg.12: *"The current culture within OCS stifles worker initiative and creativity."*

   Please share with us your reaction to this characterization. What are you doing to change the culture? What outside resources do you believe would help?

2. Also mentioned Tuesday, a question inspired a compelling OCS alumna at Tuesday's Lunch and Learn: OCS expects parents, or foster parents, to be full-time... but does OCS expect to be available 24/7 to the children in State care?

3. The CRP presenters mentioned an upcoming workload study, and their written report notes (pg. 12) that "OCS has identified three studies they would like to conduct":
   - tasks appropriate for support staff, and those which need to be done by front line workers
   - appropriate level of support staff (including SSA's and clerks) for front line workers
   - statewide staff-to-caseload ratio to determine equitable PCN placement

   Please give a status on each of these.

4. CRP Recommendation #2 to OCS (pg.13) suggests revisiting the idea of "regional intake". Can you define that for us, and outline how the process works? How is it a change from the way things have been done before?

5. The last paragraph of CRP Recommendation #2 to OCS (pg.14) reads: "we understand that OCS has a long range plan of a statewide hotline that would provide 24-hour coverage by social workers with expertise to handle these reports of harm. The barrier to implementation is funding." Please elaborate.

6. CRP Recommendation #3 to OSC (Pg. 14) reminds us that OCS is statutorily required to make "reasonable and active efforts" to help with services toward family reunification or other permanent placement for the kids. Generally, what are the courts' standards for "reasonable and active"? What variations do you see in different courts?

7. We've heard about ongoing challenges in the Southcentral Regional Office (SCRO) in Wasilla. Since the Western Region (5) was created and its cases taken off SCRO's plate, has that helped eased matters at SCRO?

8. Please share a little bit about the Indian Child Welfare Act with the committee. What does the law require? What does OCS do to comply? What challenges does it present to OCS' staff? Does OCS meet ICWAs requirements to your satisfaction? Where is there room for collaboration with Tribal and other rural partners?

9. Please update the committee on OCS' with the Tribal-State collaboration group.

10. Please share your assessment of Western Region 5's current status: successes, challenges, needs and collaboration opportunities.

11. Later, as I know expect more time is needed to gather good information, I would like a financial picture of Western region recruitment and training. How much time and how

many hours have been put into hiring (total, and average per hire)? What do new workers pre-qualifications, orientation, and training programs look like?

12. CRP's Recommendation #1 to the Legislature (pg.17) asks for a capital fund to house rural OCS workers, similar to teacher and Trooper housing in some communities – the idea being that this will ease recruitment and improve retention. While the intent here may be very good, it only scratches the surface. I believe what we really need is more commitment to hire qualified locals for these jobs whenever possible. I've heard of community members who have tried, time after time, but they're turned away for reasons that often don't make sense. Meanwhile, the quick turnover cycle continues, costing the State money and compounding trauma our children and families have already faced.

Maybe it means more community involvement and capacity-building. Maybe it means looking more closely at some existing laws affecting employment eligibility and hiring practices – and changing the rules where it's appropriate to allow you to hire good locals who will be quality staff and serve their communities better than anyone from outside possibly could. Reason suggests these locals would connect better with clients through shared cultural experience and values, and would likely also stay longer... as they have already chosen to live in these communities.

Please comment.

Thank you for considering these questions, and for your commitment to our State's children and families.

Bob Herron

Cc: Representative Wes Keller
Chair, House Health and Social Services Committee

Alaska Native Tribal Health Consortium

Organizational Chart
2/8/2012

Alaska Tribal Health System

Alaska Native Tribal Health Consortium

Outline

- Great Partnerships & Great Opportunities
- Alaska Tribal Health System introduction
- Health Initiatives
- Sustainability Issues

Great Partnerships

- Alaska Tribal Health System serves a public health function in every Alaska community
- While the federal government has a trust responsibility, Alaska Natives are also Alaska citizens
- The State of Alaska benefits from our ability to provide health care
  - Immunization rates have improved dramatically
  - Existing health care system that is partially financed by the federal government
  - GF Savings for Medicaid beneficiaries

More Opportunities to Save

- **Long Term Care**
  - **$19M annual General Fund savings opportunity statewide**
  - **$8.15 M annual GF savings in first phase:**

• ANTHC (50 beds)	$3.45 M
• Maniilaq (18 beds)	$1.41 M
• Norton Sound (24 beds)	$1.88 M
• YKHC (18 beds)	$1.41 M
	$8.15 M annual GF Savings

More Opportunities to Save

- Energy Savings for Sanitation Facilities
  - Alaska Rural Utilities Collaborative ($3 M investment)
    - Improved water safety, steady local employment, bulk fuel and equipment purchasing
    - Adds 15 communities
  - Rural Utility Energy Audits & Energy Efficiency Upgrades ($0.8 M investment)
    - Opportunity for 50% energy savings
    - 15 new communities

More Opportunities to Save

- Patient Housing
  - $19.5 M investment
  - 100 bed facility
  - Increases our ability to provide specialty medical care to Alaska's rural citizens
    - Cardiology
    - Ear, Nose, Throat (ENT)
    - Oncology
    - Neurology
    - Orthopedics

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 561 federally recognized Tribes.**

IHS Delivery Models: I/T/U

- Indian Health Service (IHS) direct provided care
  - 33 hospitals
  - 59 health centers
  - 50 health stations
- Tribally delivered care
  - 15 hospitals
  - 221 health centers
  - 97 health stations
  - 176 Alaska village clinics
  - 9 residential treatment centers
- Urban Indian Centers
  - 34 projects provide a variety of health & referral services

Alaska Native health history

- ***1900-1970:*** **Health care for Alaska Natives was provided by the U.S. government in recognition of government to government relationship between Tribes and the U.S.**

- ***1970-1998:*** **Alaska Natives organized health care organizations and assumed ownership of health services that were previously provided by the Indian Health Service under Self-Governance legislation**

- ***1998-2007-Future:*** **All Alaska Native health care is provided by Alaska Native organizations**

Why Tribal Ownership?

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

Alaska Tribal Health System

- Voluntary affiliation of 30 Alaskan tribes and tribal organizations providing health services to Alaska Natives/American Indians (7,000 employees)

- Each is autonomous and serves a specific geographical area

Alaska Tribal Health Compact

- Alaska Native Tribal Health Consortium - 229
- Aleutian Pribilof Is. Assn - 13
- Arctic Slope Native Assn - 8
- Bristol Bay Area Health Corp - 34
- Chickaloon
- Chugachmiut - 7
- Copper River Native Assn - 5
- Council of Athabascan Tribal Governments - 10
- Eastern Aleutian Tribes
- Native Village of Eklutna
- Eyak
- Kenaitze Indian Tribe
- Ketchikan Indian Community
- Knik Tribal Council
- Kodiak Area Native Assn - 11
- Maniilaq Assn - 12
- Metlakatla Indian Community
- Mount Sanford Tribal Consortium - 2
- Norton Sound Health Corp-20
- Seldovia Village Tribe
- Southcentral Foundation
- SouthEast Alaska Regional Tribal Health Consortium - 18
- Tanana Chiefs Conference - 42
- Yakutat Tlingit Tribe
- Yukon Kuskokwim Health Corp - 58

Alaska Native Demographics

- Alaska Natives represent 20% of Alaska's population
  - 140,000 Alaska Natives
  - projected to be 163,000 by 2015

- Median age is 23.6 years compared to
  - 35.3 years for U.S. All Races and
  - 32.4 years for All Alaskans

ATHS Service Population

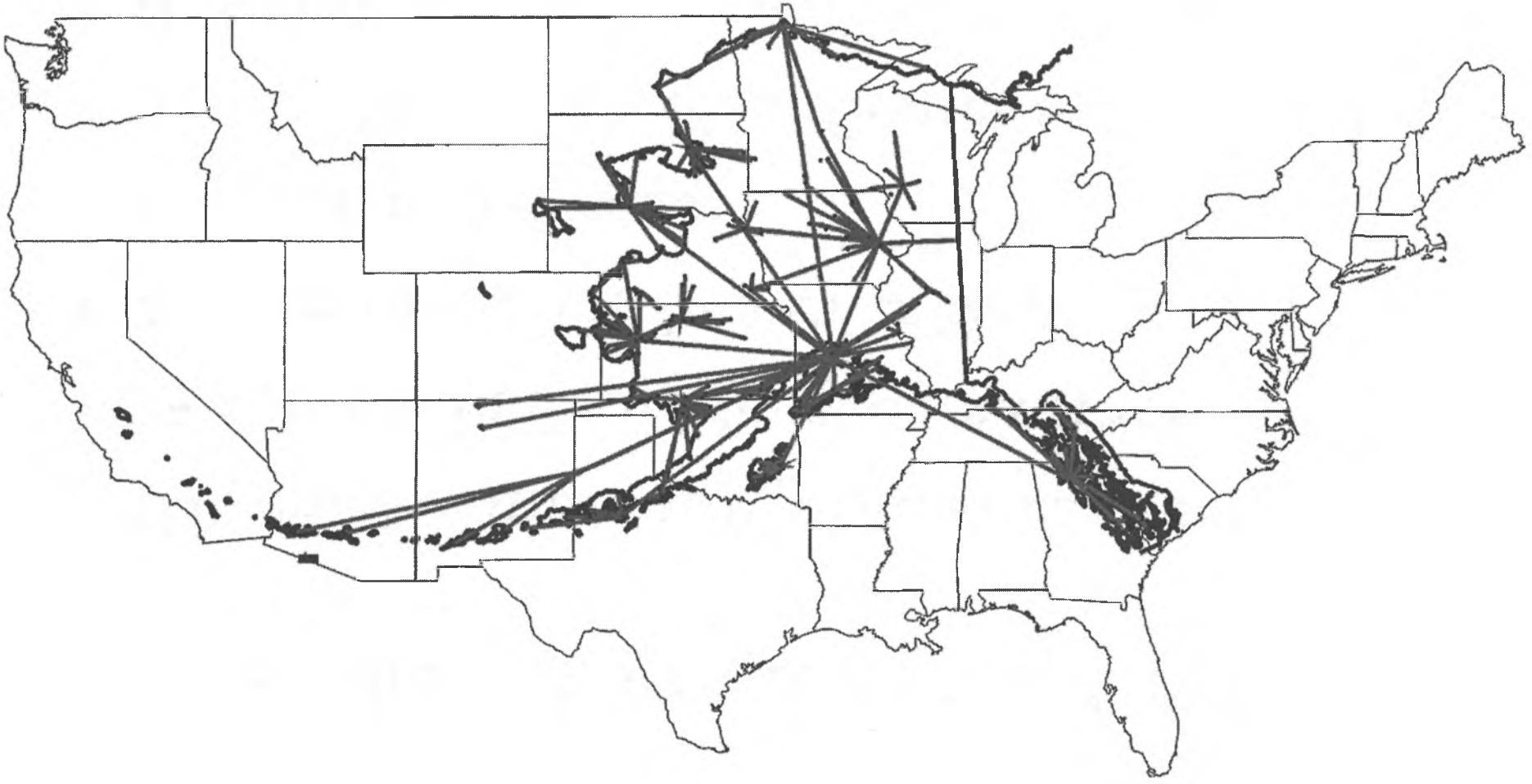
– Anchorage/Mat-Su valley	47,000	33%
– Rural Southcentral Alaska	13,200	9%
– Arctic Slope (northern coast):	4,300	3%
– Maniilaq (northwest coast):	7,600	6%
– Norton Sound (west coast):	7,400	5%
– Bristol Bay (southwest):	5,300	4%
– Yukon-Kuskokwim (southwest):	26,200	18%
– Southeast Alaska:	16,000	12%
– Interior Alaska:	14,000	10%
TOTAL ALL REGIONS:	140,000	100%

Medical Care Service Levels

- 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

THE ALASKA NATIVE HEALTH CARE SYSTEM REFERRAL PATTERN

Same Scale Comparison - Alaska Area to Lower 48 States

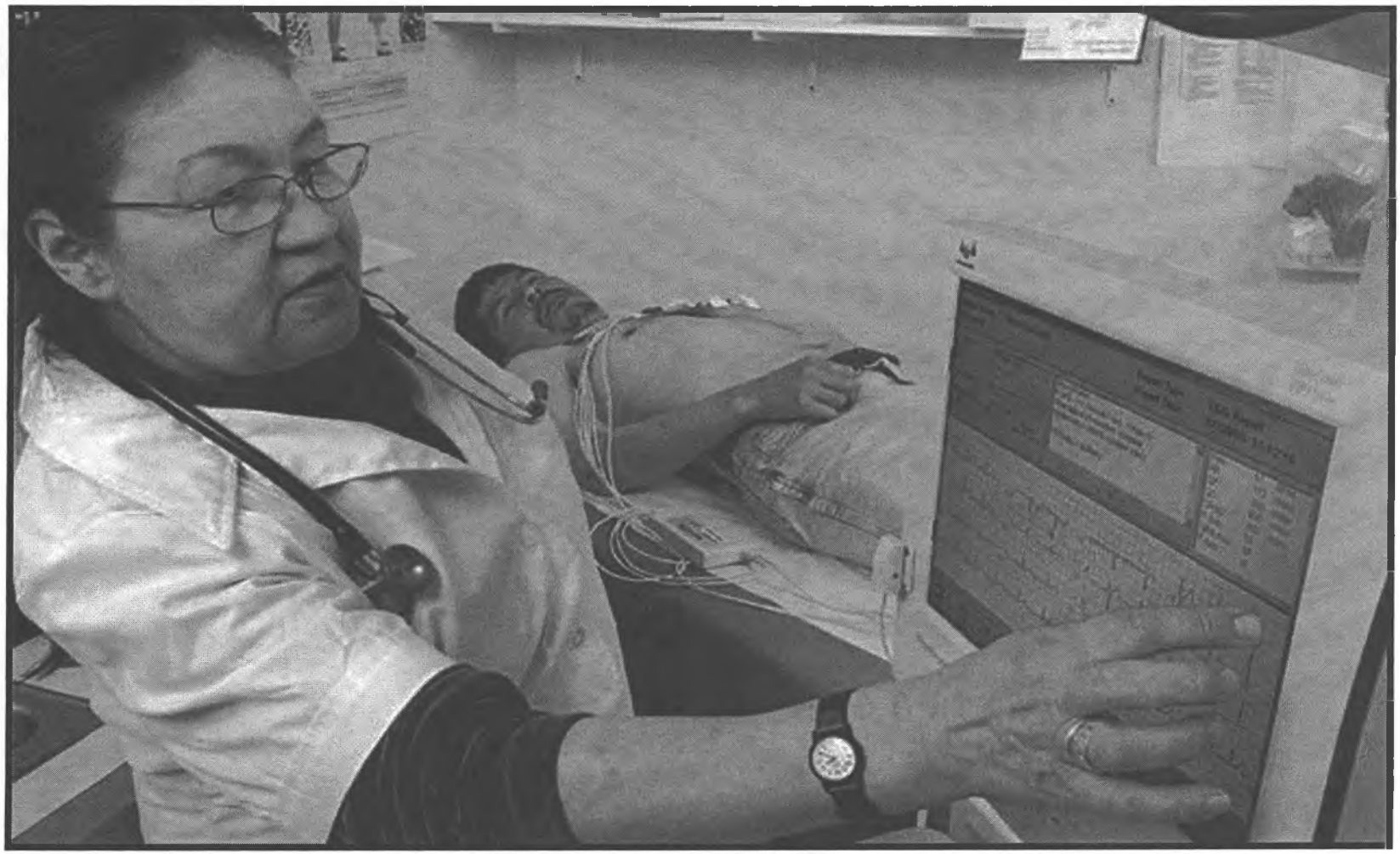


Village-Based Medical Services

- 180 Small Village 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: 300 residents

Community Health Aide/Practitioners



Subregional Clinics

- Located in Hub Communities
- Serve surrounding small villages
- Services
  - Mid-level providers
  - Modest radiology services
  - Modest lab services
  - Dental operatories
  - Behavioral Health Professionals

Regional Hospitals

- Arctic Slope Native Association (6; Barrow)
- Bristol Bay Area Health Corporation (32; Dillingham)
- Maniilaq Association (12; Kotzebue)
- Norton Sound Health Corporation (20; Nome)
- SouthEast Alaska Regional Health Consortium (18; Sitka)
- Yukon Kuskokwim Health Corporation (58; Bethel)

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

Alaska Native Tribal Health Consortium

- Created in 1998 with Congressional authorization
- Provider of statewide health services, supporting all Alaska tribal health organizations and communities
- 1,900 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

Alaska Native Medical Center

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

Alaska Native Medical Center

- 150 beds
- 9,100+ inpatient admissions annually
- 383,000+ outpatient admissions annually
- 1,500+ infants delivered annually
- 11,000+ surgeries and endoscopies
- 250 medical staff, 700+ nurses
- $250 M operating budget (ANTHC+SCF)

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)

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

Health Facilities

- Annual federal investment in building, renovating, and maintaining Alaska Native health facilities is estimated at $55 million

- Nearly 100 primary care clinics have been replaced, another 50+ need replacement

- Long-term care facilities are also needed

Sanitation Funding: 2004-2011

- All sources (national tribal allocations, Alaska specific appropriations, and required state match)
  - declined by over $49M between FYs 2004-2011
- Alaska specific appropriations and required state match
  - dropped by $57M or 58%
- FY 10 budget was the lowest in over 10 years
  - $41M decrease from last year
- Need for operational resources

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

Major Alaska Native Health Initiatives

- *Care coordination* for chronic/high-acuity patients
- *Electronic Health Records* deployment
- *Tribal Long-Term Care* (residential and community-based services development)
- *Alternative health resources* enhancement (Medicaid, Medicare, Denali KidCare, private insurance)
- *Wellness/health promotion* effort

Sustainability Issues

- ***Severe underfunding of the Indian Health System results in layoffs & reduction in services:***
  - ***Funded at 50-60% of Level of Need***

- ***Reliance on 3rd party insurance***

Sustainability Issues

- ***As resources get tighter, individual American Indians / Alaska Natives and the IHS facilities that provide their care will feel the impact more than any other***

Why?

- ***Highest rates of unemployment are in Indian Country***
- ***Some of the lowest income levels***
- ***Some of the poorest health status***
- ***Rural communities***
  - ***Access to care is a problem***
  - ***High cost of providing care***
  - ***High cost of living where limited incomes get stretched even more***

Impact

- ***When our people do finally get the care they need,***
- ***they have traveled farther with money they simply don't have,***
- ***are sicker than the average person,***
- ***and are seen in clinics / hospitals that have fewer resources than most other clinic / hospitals in the country that also,***
- ***have a higher cost of providing care.***

Sustainability Issues

- ***Care for Returning Veterans***
  - *Enhance the existing Alaska Tribal Health System's capacity to provide health care to veterans who live in rural Alaska*
  - *Authorize the VA to reimburse IHS facilities for care to veterans and their families*
    - *Flexible enough to provide behavioral health and telemedicine services in the primary care setting*
    - *Precedent already exists in lower 48 states*

Sustainability Issues

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

Sustainability Issues

- 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

Sustainability Issues

- 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

Sustainability Issues

- 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 locations in which there is no other health care provider

Federal Hot Topics

- General Health Reform Implementation
- IHCIA Implementation
- Electronic Health Records
- Veterans Care
- Sanitation Facilities
- Medical Equipment need

Real Life Test

- At the end of the day, are people getting enrolled in the programs that we know they are eligible for?
- Do they have meaningful access to care?
- Do the programs that provide their health care get reimbursed sufficiently to be sustainable over time?

Real Life Opportunities

- Are we investing appropriately today to maximize GF savings tomorrow and into the future?
- Long Term Care
- Sanitation Facilities Operational efficiencies
- Patient Housing opportunities to maximize specialty care

Questions?

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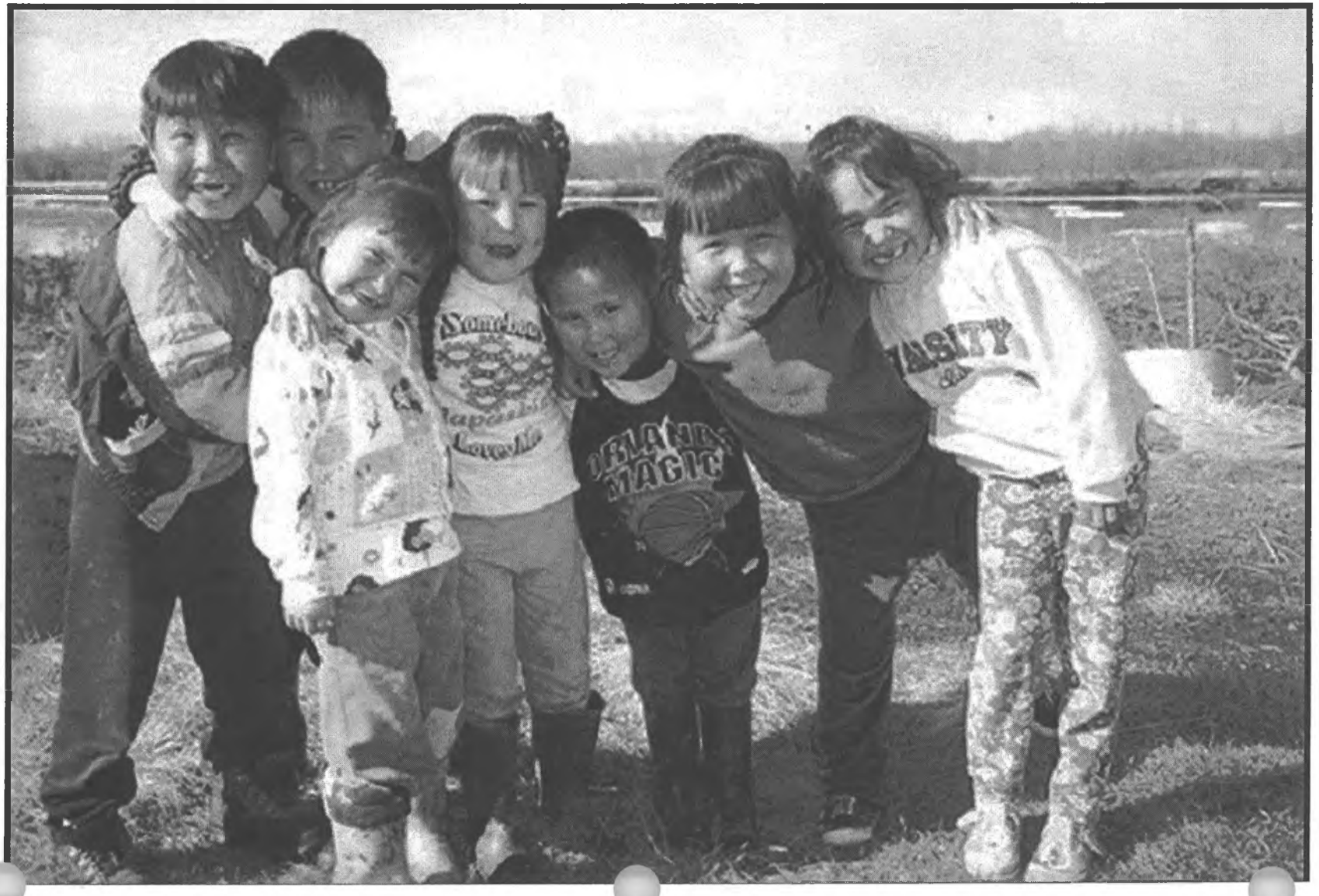
Phone 907-729-1900
Cell 907-350-0572

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



Next Steps ...

The AFHCAN Telehealth Program

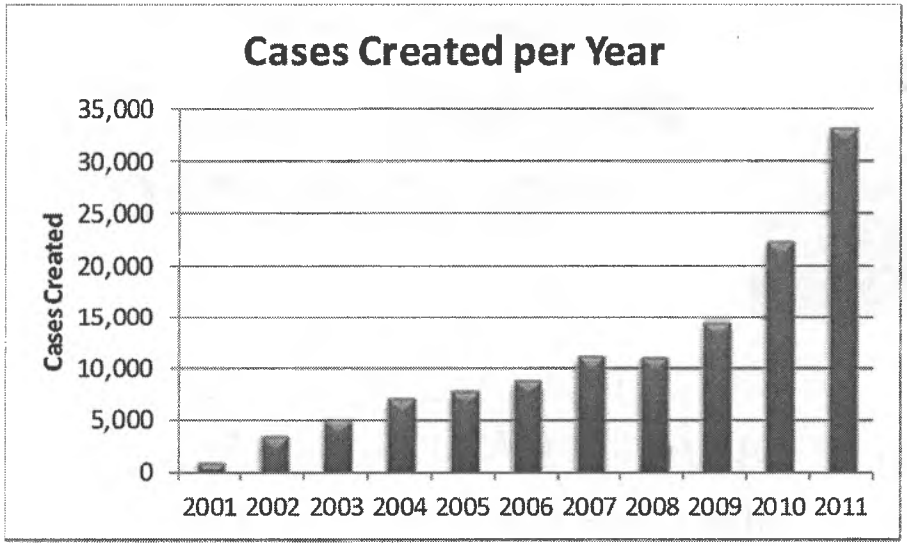
Stewart Ferguson, PhD
Chief Information Officer (CIO)
Alaska Native Tribal Health Consortium

"Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status."

"... "telehealth" .. is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. "

ATA Defining Telemedicine
http://www.americantelemed.org/news/definition.html

AFHCAN Telehealth



- 11 year Operational History
  - 33,000 cases/year
  - 125,482 Cases (ATHS)

- Installed Customer base includes:
  - Alaska: 248 sites, 44 organizations
    - 59 operational systems in 2011
    - 1,443 providers in 2011
    - 22,763 patients in 2011
  - Other states and countries

ALASKA's PHYSICIANS

- 49% of all physicians in Alaska are primary care physicians (2002 data). U.S. average is 28%

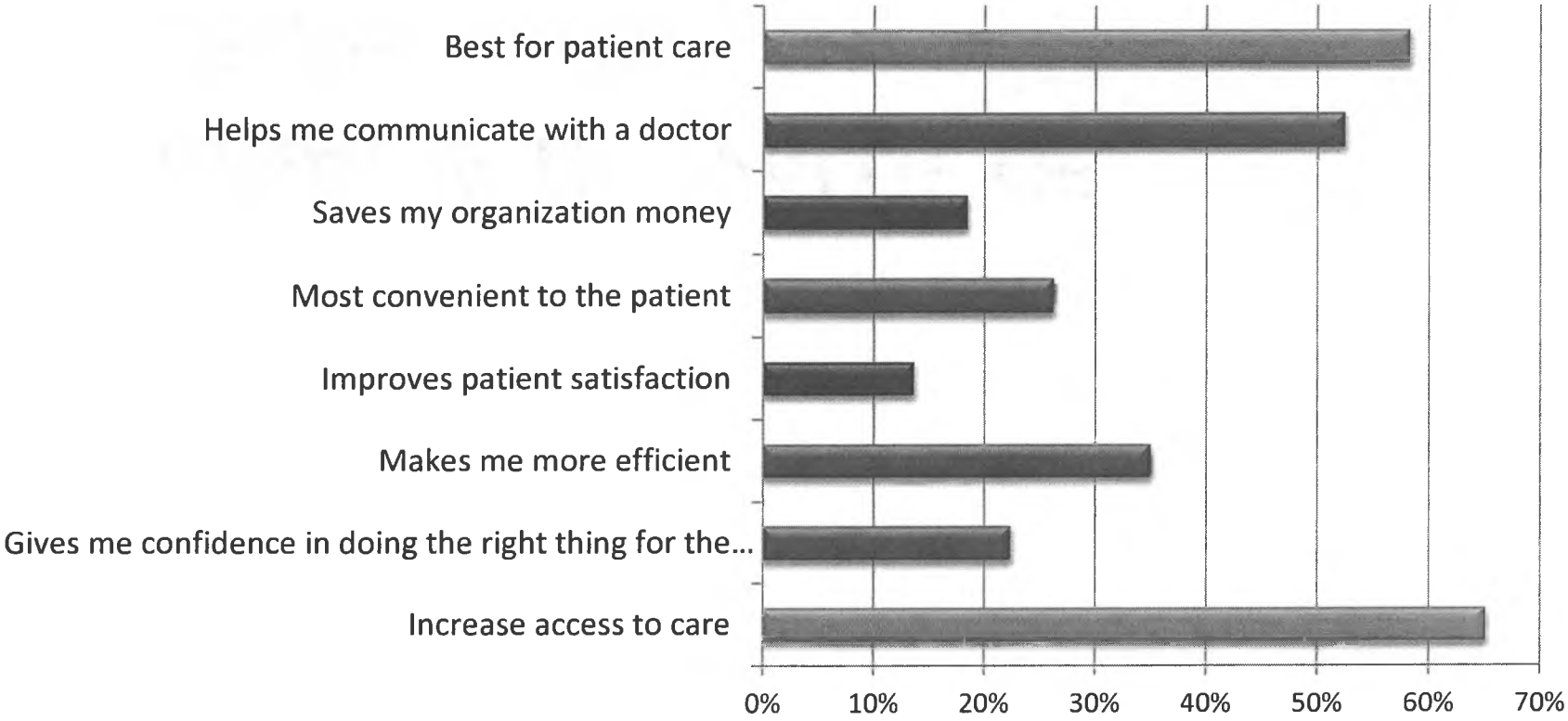
- Alaska is 48th in "doctors to residents" ratio
  - **65% are located in Anchorage**
  - Shortages in many specialties
  - 579 Community Health Aides in 200 villages provide nearly ½ million encounters each year.

DISPARITIES: Health Staff per 100,000 people

	AI/AN	U.S.	Gap
MD	73.9	220.6	66% Lower
DD	24.0	61.8	61% Lower
Nurse	229.0	849.9	73% Lower

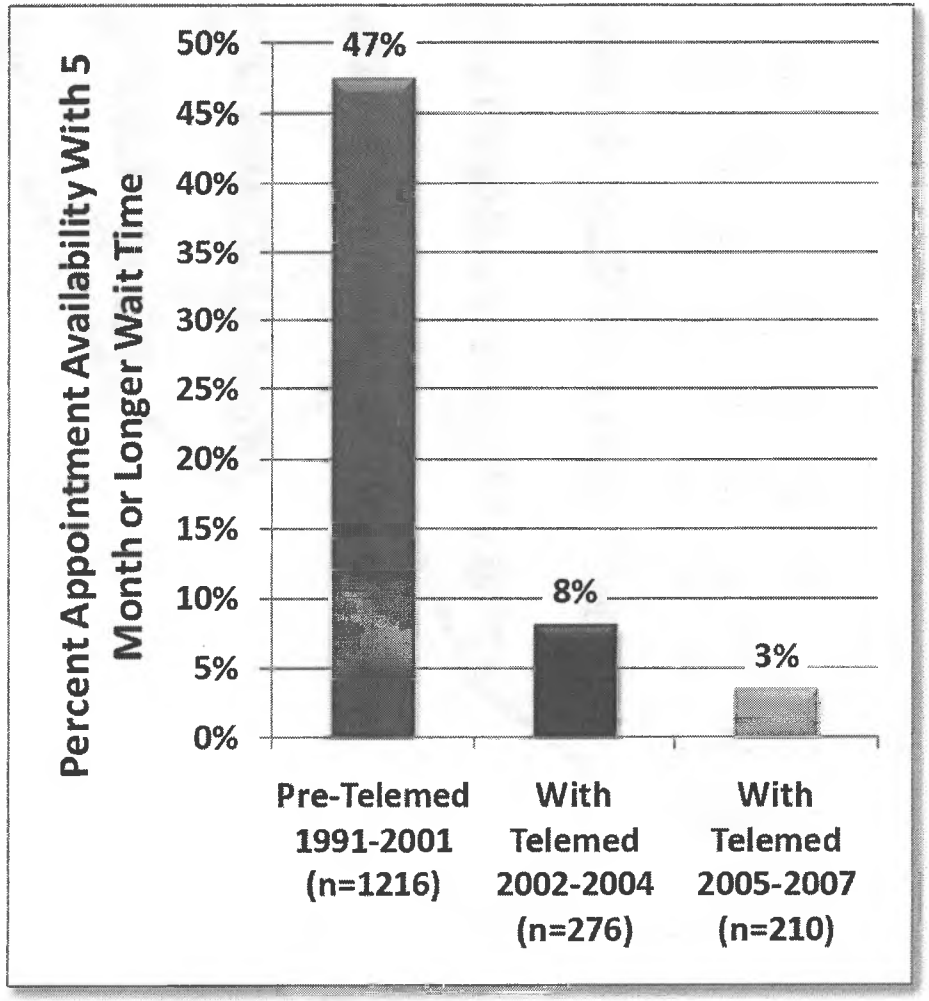
WHAT IS THE VALUE OF TELEHEALTH?

Why do you do Telemedicine?



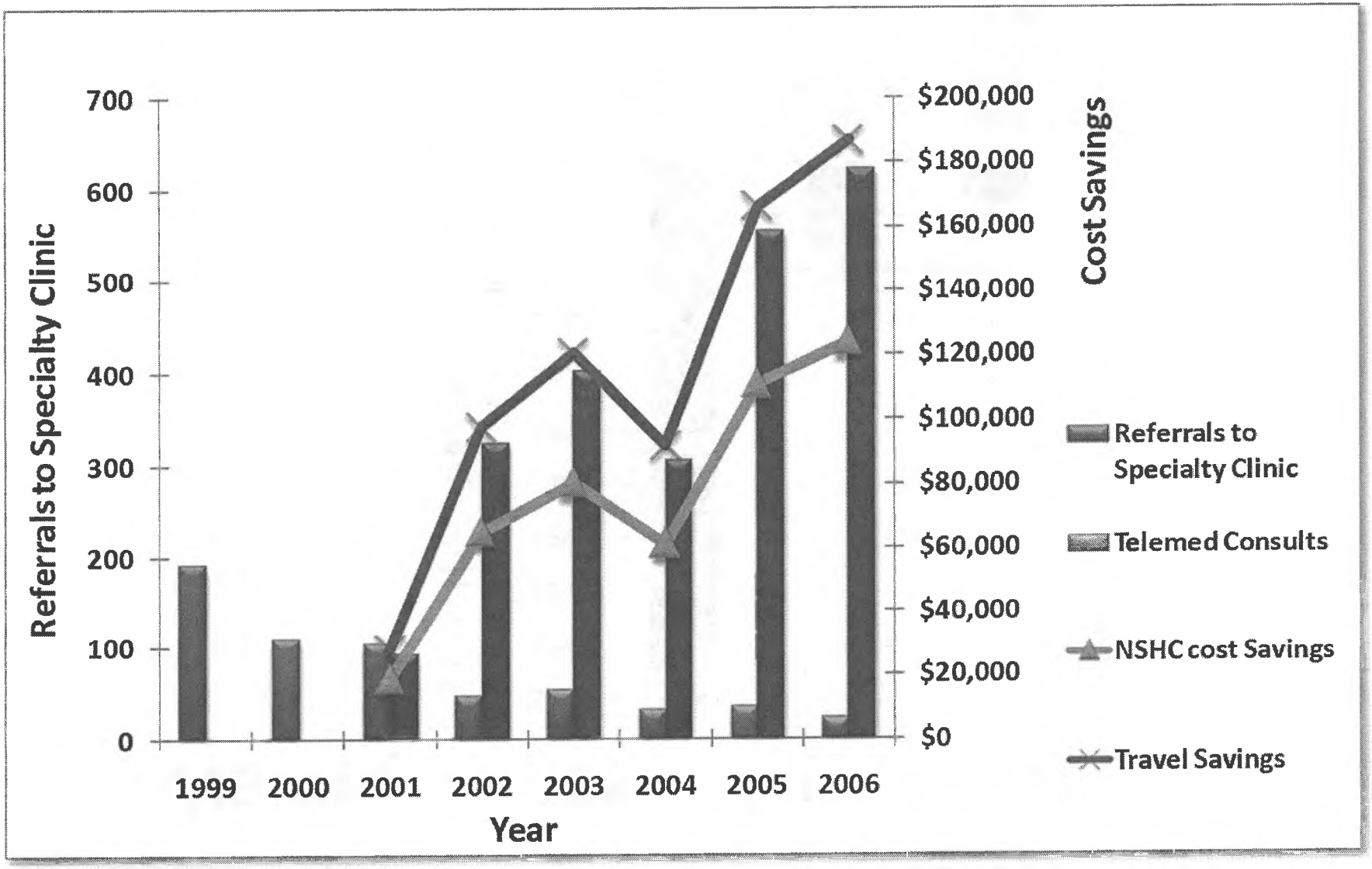
- Best for patient care
- Increased access for care

Telehealth Impact on Extended Waiting Times (> 4 months)



Data courtesy of Phil Hofstetter

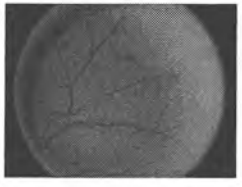
Access

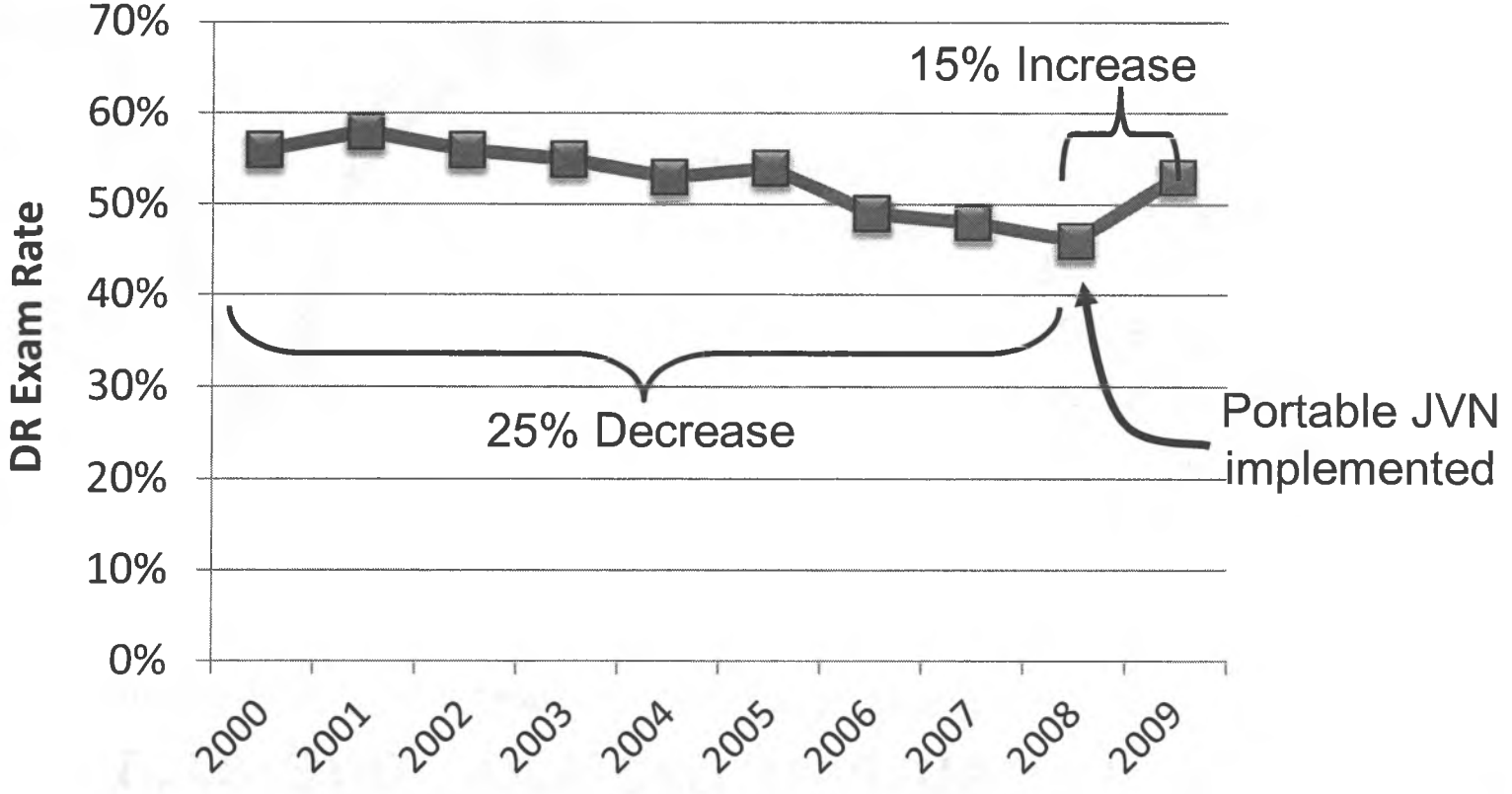


Data courtesy of Phil Hofstetter

Joslin Vision Network (JVN)
Portable JVN Pilot

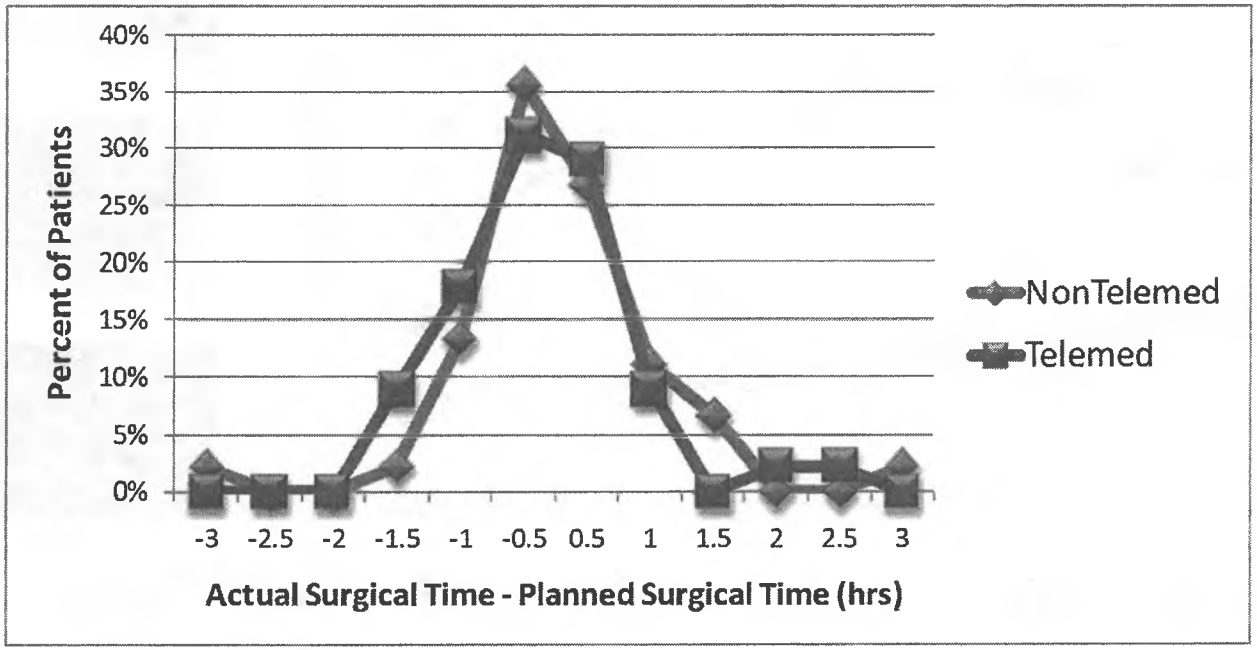
Deployment of the IHS-JVN in Alaska using a portable platform reversed a seven year decline in rates for the state





Pre-Operative Planning for Ear Surgery Using Store-and-Forward Telemedicine

John Kokesh M.D., A. Stewart Ferguson Ph.D., Chris Patricoski M.D.

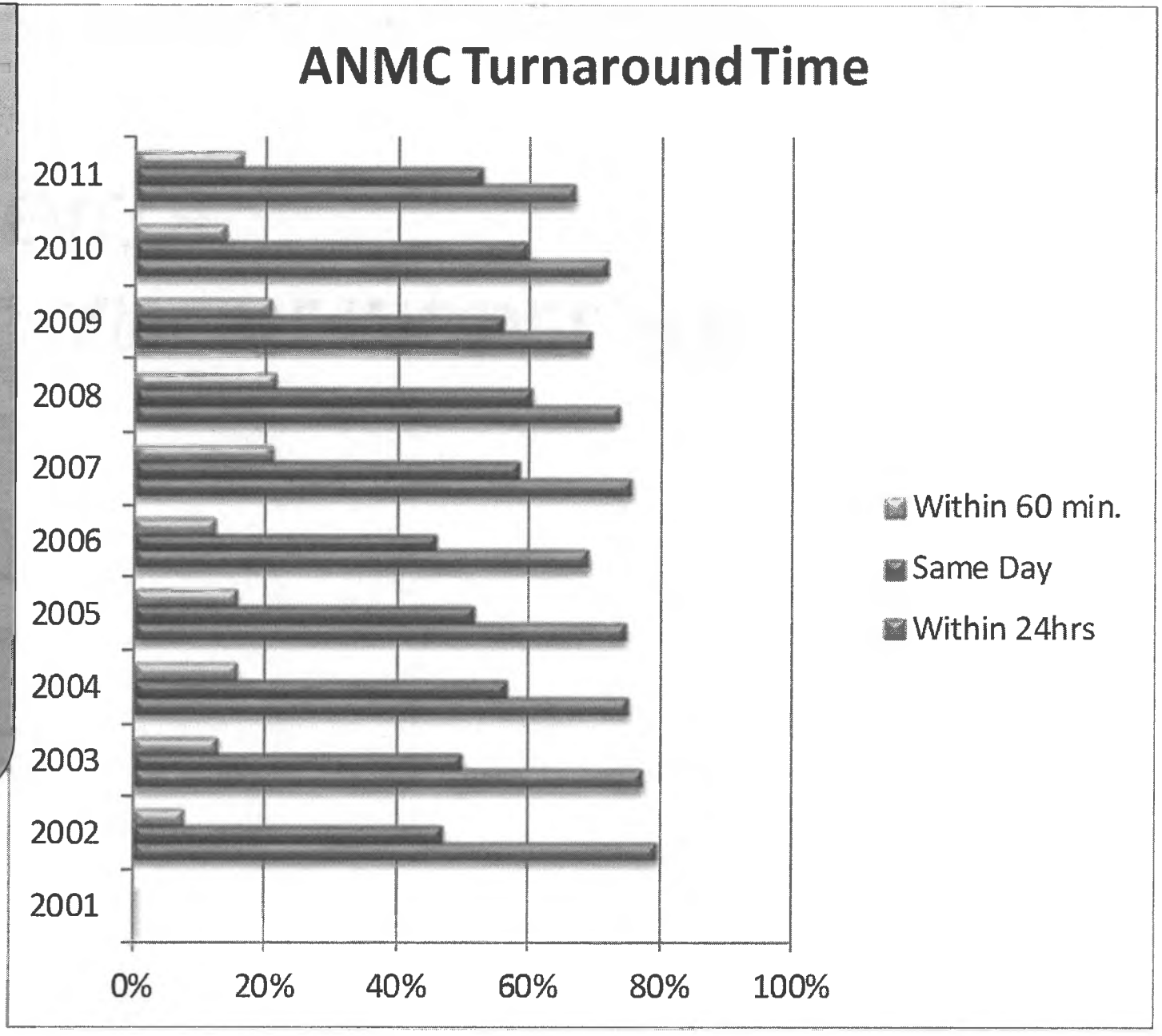


The average difference **was not statistically different** between the two groups: 32 minutes for the telemedicine evaluation group and 35 minutes for the in-person evaluation group

20% of all specialty consultations are turned around in 60 minutes.

50%-60% are turned around in the same day.

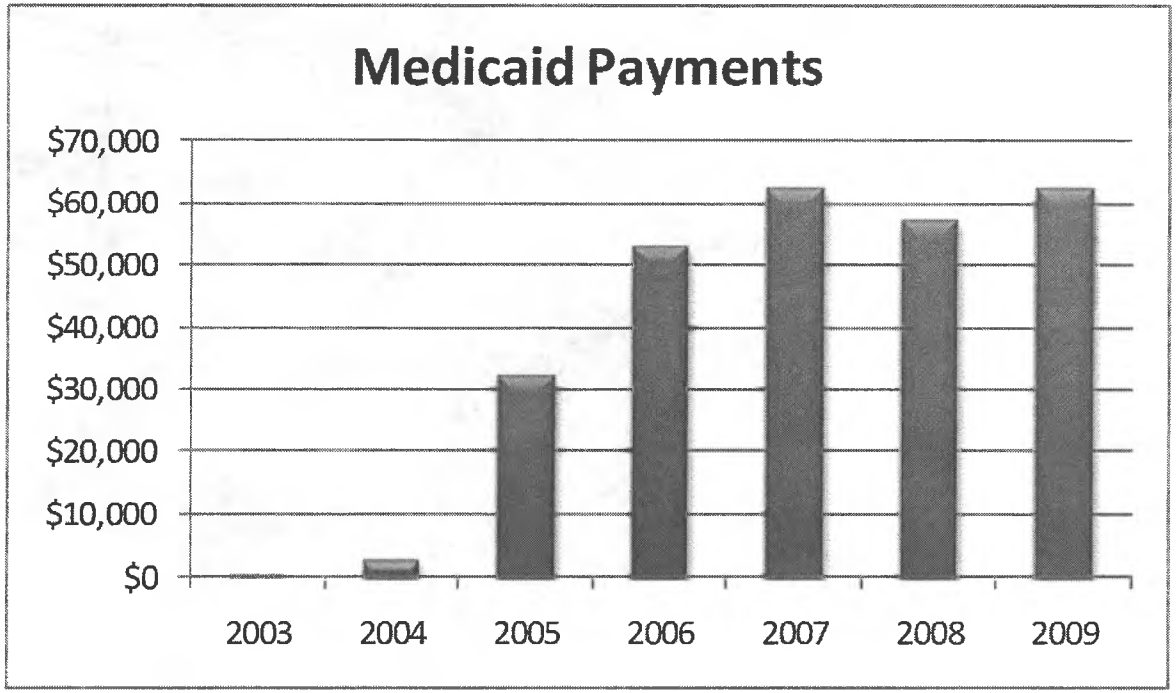
70%-80% are turned around within 24 hours.



THE FINANCIAL MODEL FOR TELEHEALTH

Medicaid-Eligible Patients

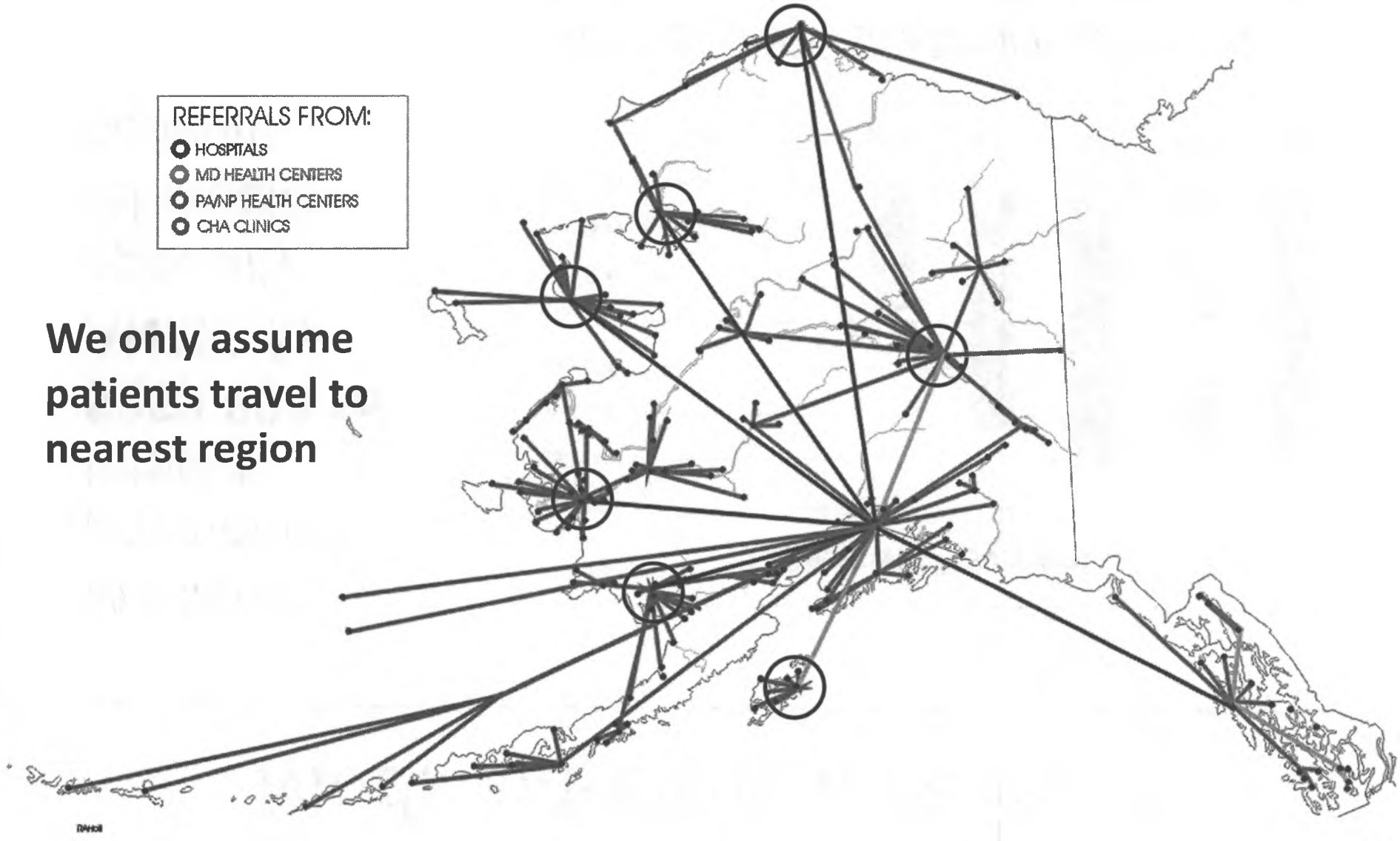
Medicaid payments totaled **$269,893 to ANMC** for specialty telehealth consults.



A total of 5,925 telehealth specialty consults with provided to 3,663 unique patients.

THE ALASKA NATIVE HEALTH CARE SYSTEM

Typical Referral Patterns



We only assume patients travel to nearest region

Medicaid Study: 2003-2009

Decreased Travel = Cost Savings

	Quantity	Cost
Claims Paid by Medicaid	**4,482**	**($269,894)**
Telemedicine Prevented Travel	**3,662**	**$3,116,034**
Net Savings Realized by Medicaid		**$2,846,140**

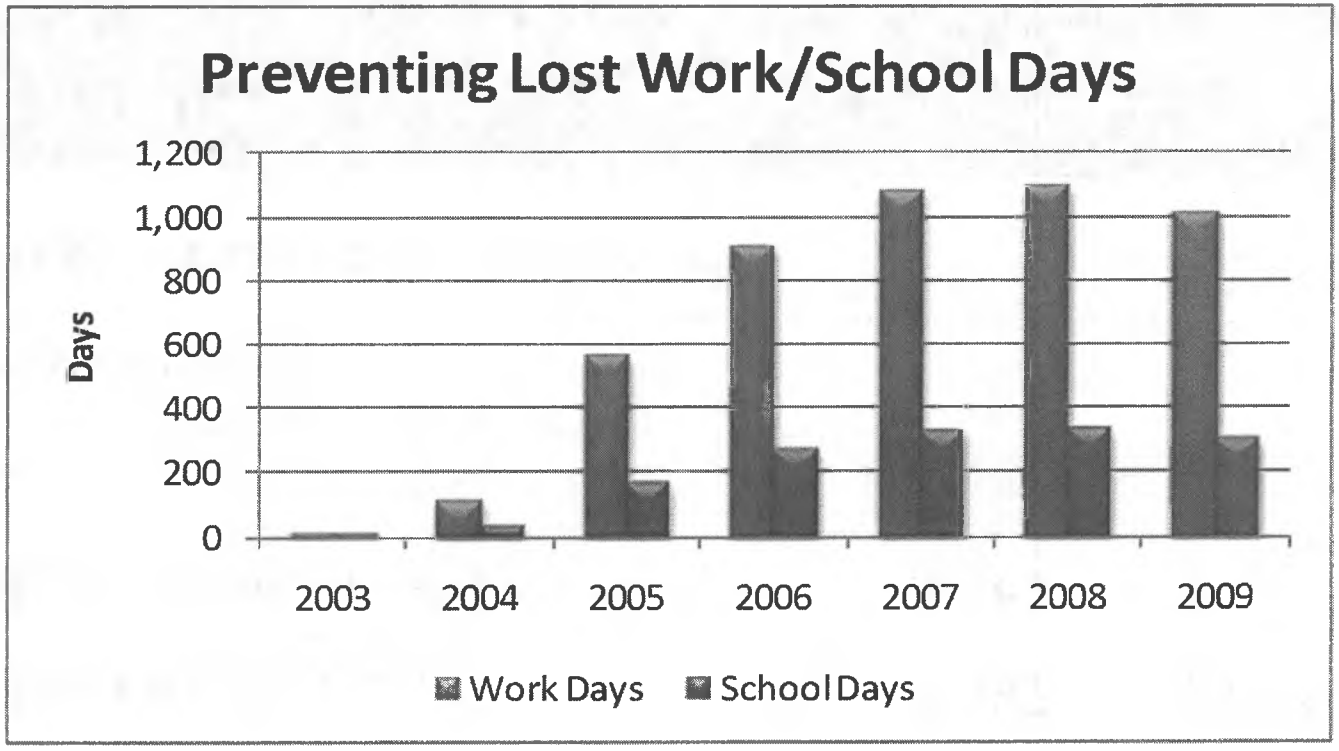
Notes:

- Travel is saved for 75% of all patients.
- Assume all patients under 18 need an escort
- Travel costs based on 1 week advance fares

Note: For every $1 spent by Medicaid on reimbursement, $10.54 is saved on travel costs.

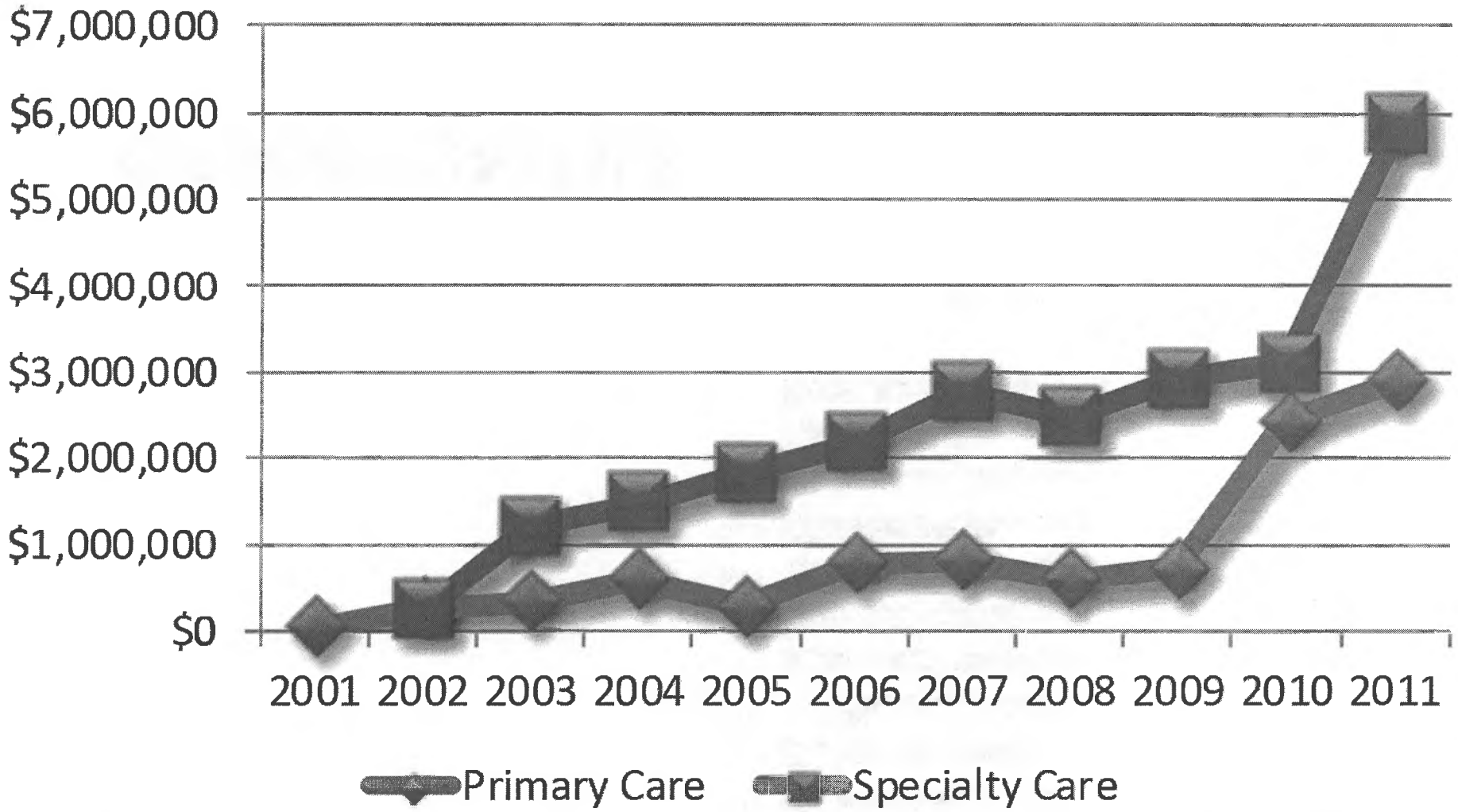
The value of using outreach clinics saved another $3.4m in travel costs

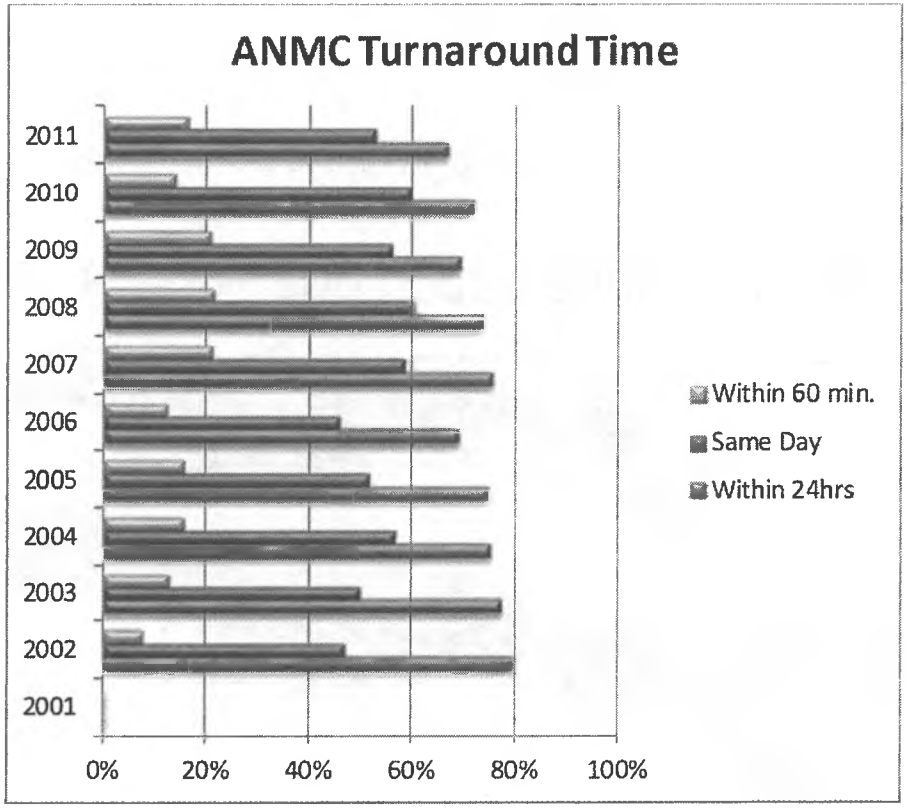
Lost Work Days/ School Days



Since 2003, telehealth prevented an estimated 4,777 lost days at work (at a cost to Medicaid of $56.49 per work day saved) and a total of 1,444 lost days at school for the patients in this study.

Annual Travel Savings (by Case Role)





OPPORTUNITIES

In FY11, 301 pediatric patients were transported from the YKHC by LifeMed at a cost to Medicaid of $2.86 million

Average cost: $9494 per patient

Telehealth may prevent 20% of such transports.

In FY11, the total amount spent on non-emergent medical travel and accommodation for all IHS patients in Alaska was $38.6 million

Patients aged 0-18 years accounted for 53.7% of all travel & accommodation costs statewide

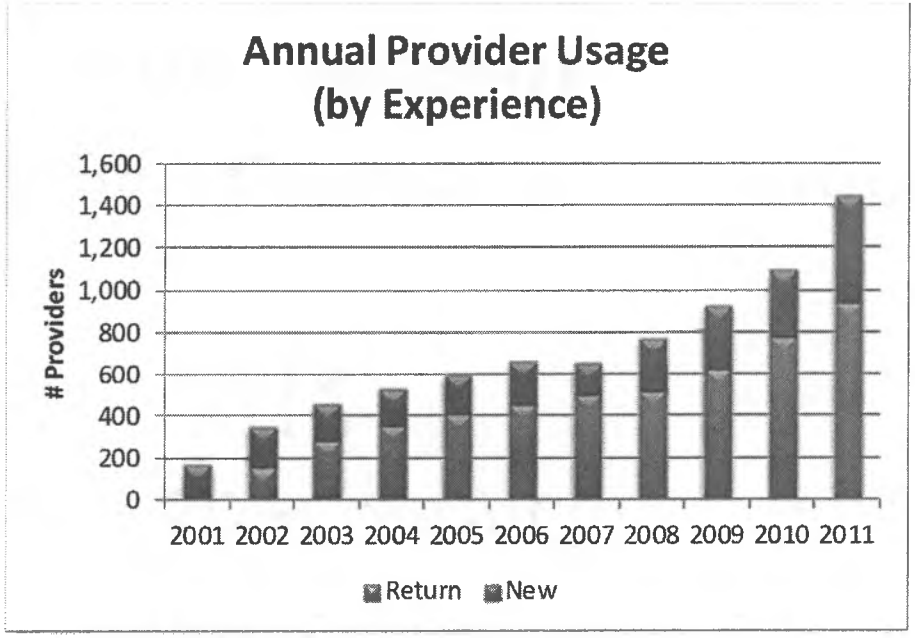
60,120 patients (that reside outside of the Anchorage bowl) will have specialty clinic visits at ANMC in 2012

22% will only require an initial consultation, without additional visits to the specialist

Telehealth could prevent 9,920 travel incidents, and save $2.18M in travel costs

Reliable Service Has a Cost

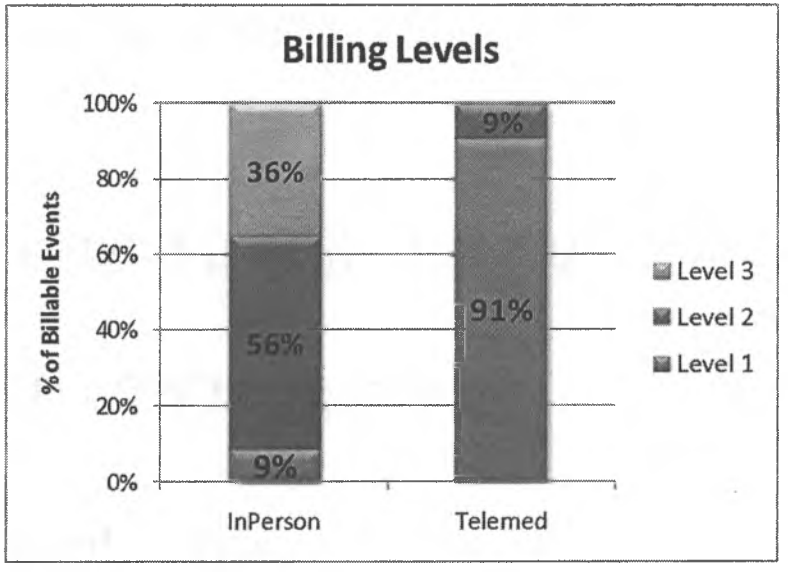
- Staffing at Remote Sites
  - New duties and effort
  - Training and Development
- Staffing at Hub
  - Not champion based
- Infrastructure Costs
  - Equipment
  - Connectivity
  - Competition with EHR



Who Reaps the Financial Benefit?

- Telehealth promotes focused, efficient consultative model.

- Telehealth revenue is 45% less compared to inperson revenue
  - Telehealth → Level 1 (91%)
  - InPerson → Level 2 (56%), Level 3 (36%)
  - Single procedure versus multiple procedures



Reimbursement model undervalues **system** benefits from S&F telemedicine

- Cost savings (travel, loss of time from work)
- Improved access for care
- Addressing disparity in care
- Clinical outcomes

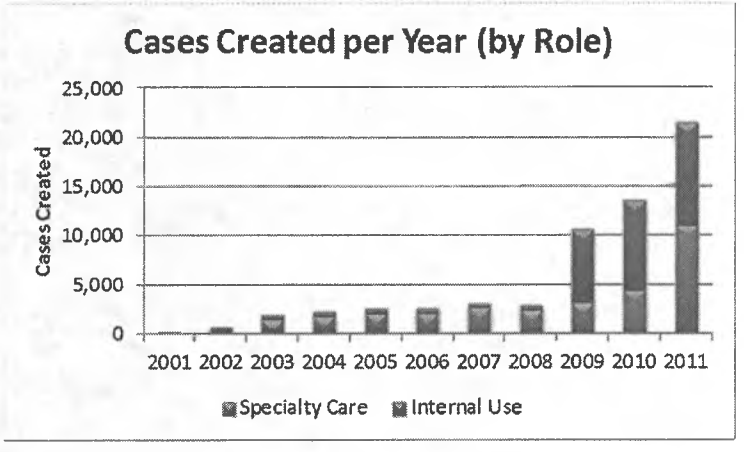
Summary

- Alaska enjoys a very supportive "reimbursement" climate.
  - Medicaid, Medicare, 3rd party payers.
  - Office of the Commissioner is very supportive
- Better alignment of revenue with costs will greatly incentivize expansion.
  - The current Evaluation and Management (E&M) coding system is an imperfect fit.
- We need to work together to identify opportunities, test new models, and scale the models that work.

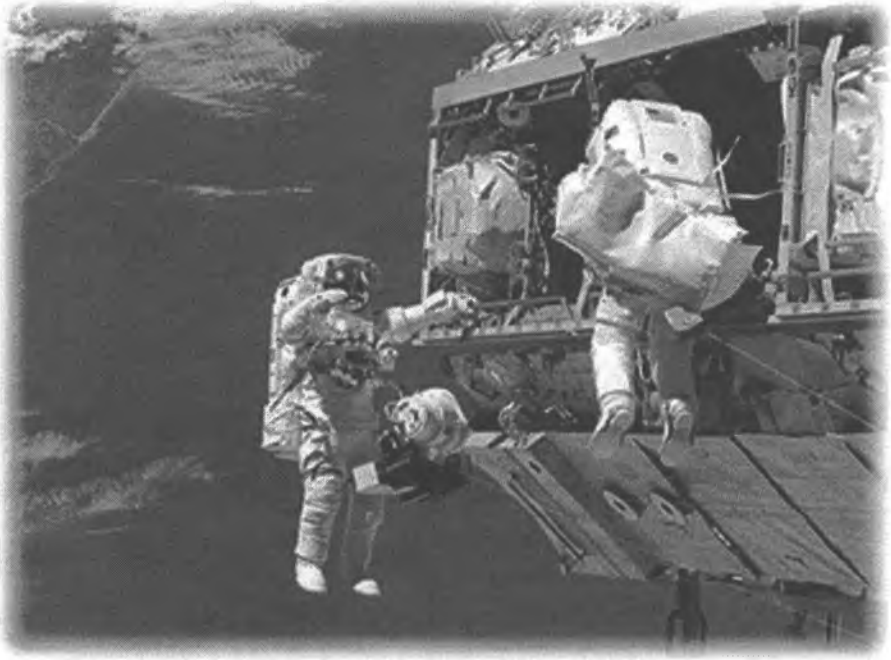
Higher Quality
Lower Cost

Care Closer to Home

- Statewide Pediatric Subspecialty Program
  - Expert Mentoring
- Palliative Care (End of Life, Chronic Care)
  - JIT (Just in Time) Training
- Expert Triage Model
- Travelling Providers
- Workforce Development
  - Dentist Supervisors
  - Rural Telehealth Coordinators
- Explore new payment models



Health Care Innovation Challenge
Center for Medicare & Medicaid Innovation



Thank You

Stewart Ferguson, PhD

Alaska Federal Health Care Access Network (AFHCAN)

Alaska Native Tribal Health Consortium

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sferguson@anthc.org

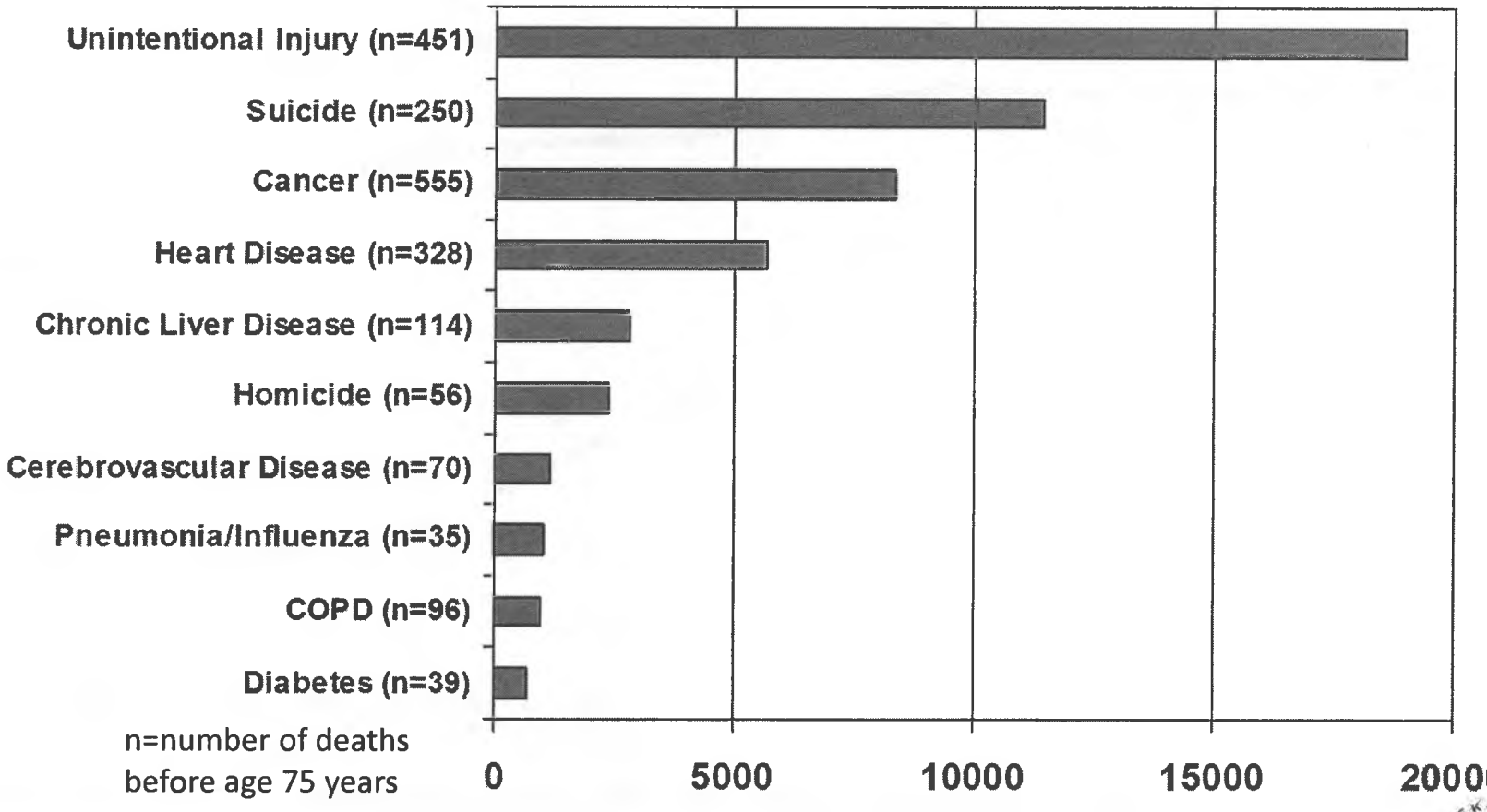
Alaska Native Tribal Health Consortium—Role in Public Health and Health Education

Jay C. Butler, MD
Senior Director, Division of Community Health Services

ANTHC Division of Community Health Services: Core Services

- Health surveillance and data analysis
- Disease prevention and health promotion
- Health education and research
- Technical assistance and statewide subspecialty care
- Public health performance improvement

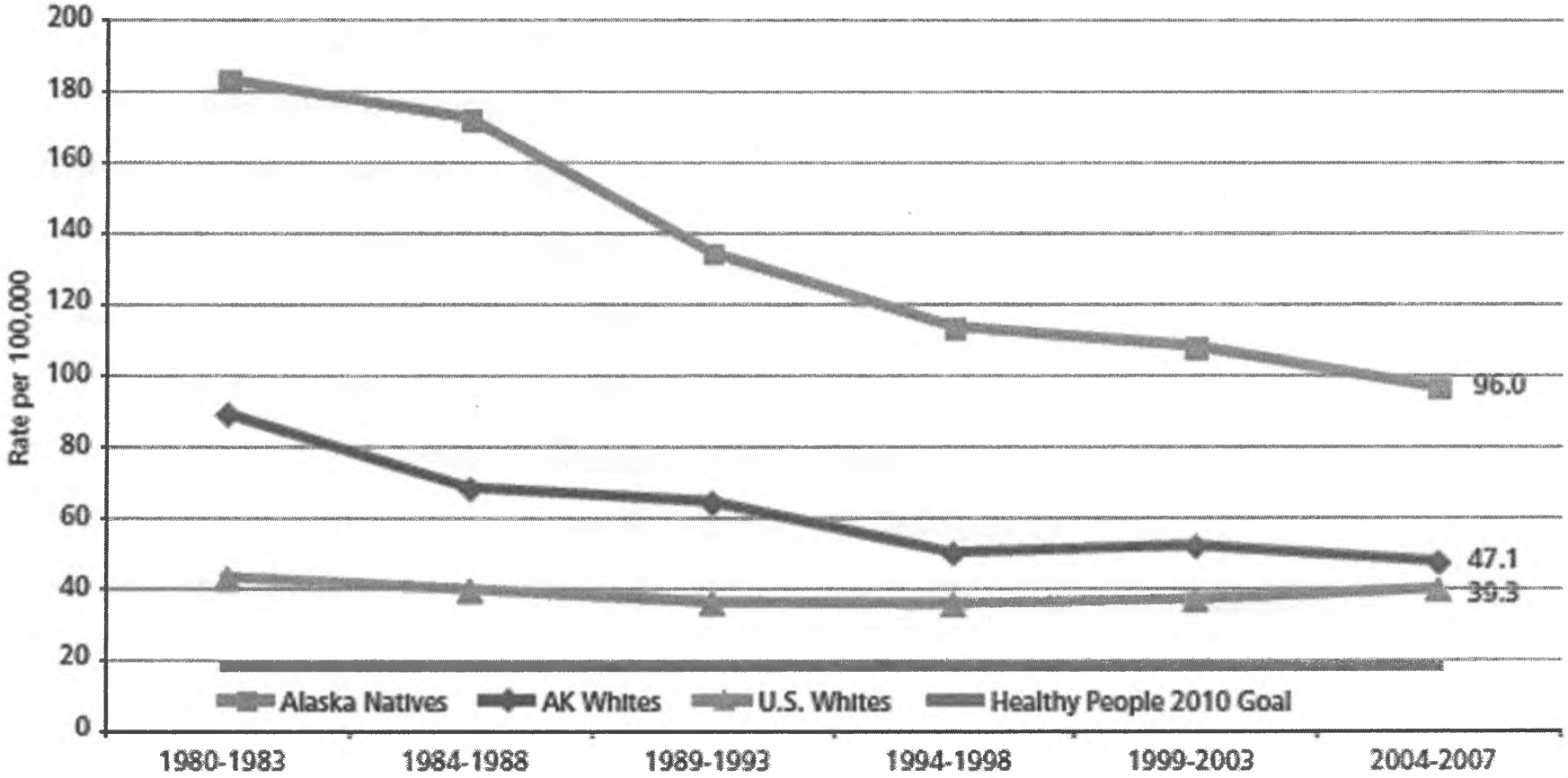
Years of Potential Life Lost, Alaska Natives, 2004-08



Source: Alaska Epidemiology Center, ANTHC; Alaska Bureau of Vital Statistic

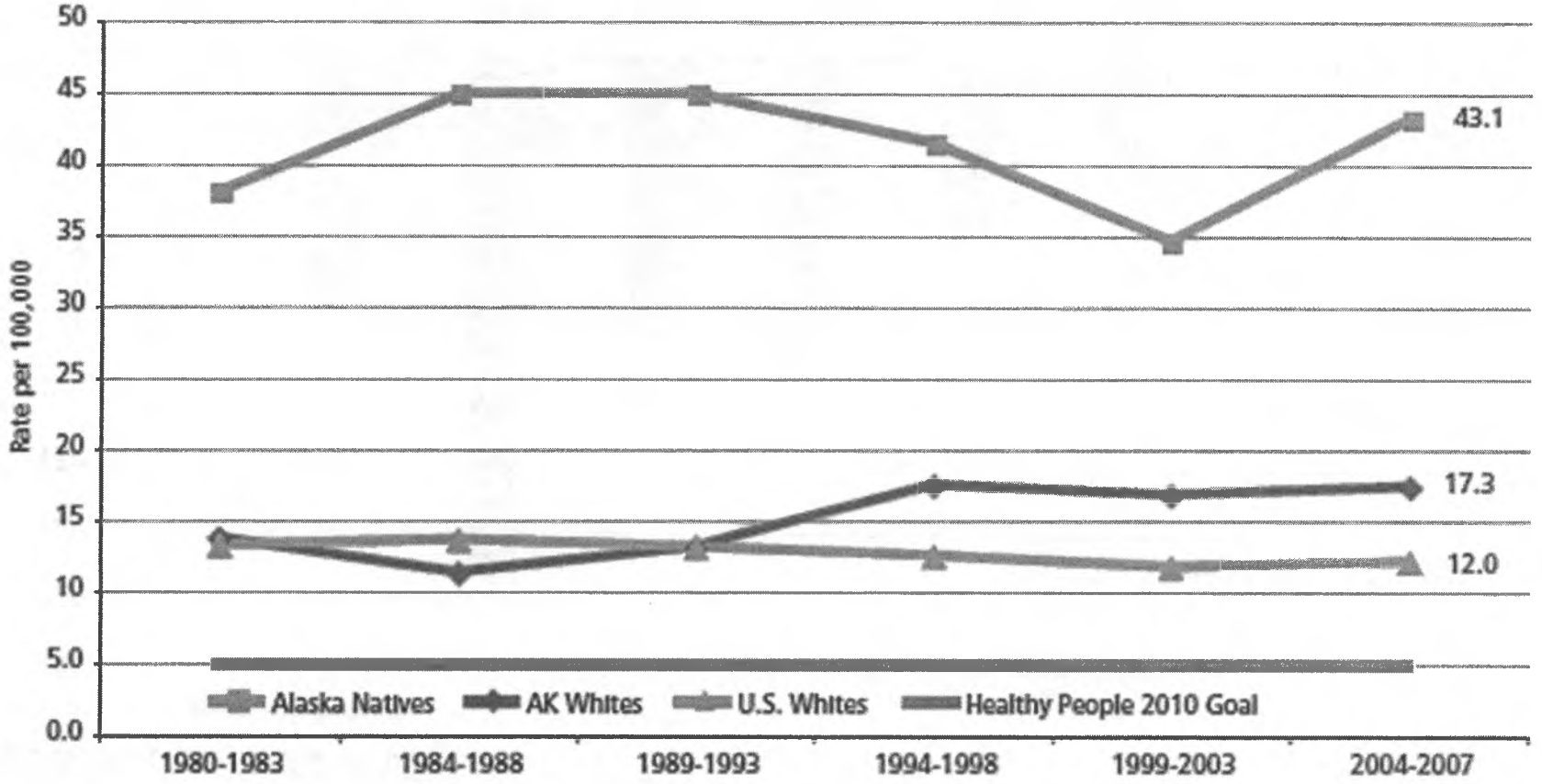
Average Annual Age-Adjusted Unintentional Injury Death Rates per 100,000, 1980-2007

Data Source: Alaska Bureau of Vital Statistics
U.S. Data Source: Surveillance, Epidemiology, and End Results (SEER) Program
U.S. Whites and AK Whites 2004-2007 data point is for 2004-2005 only



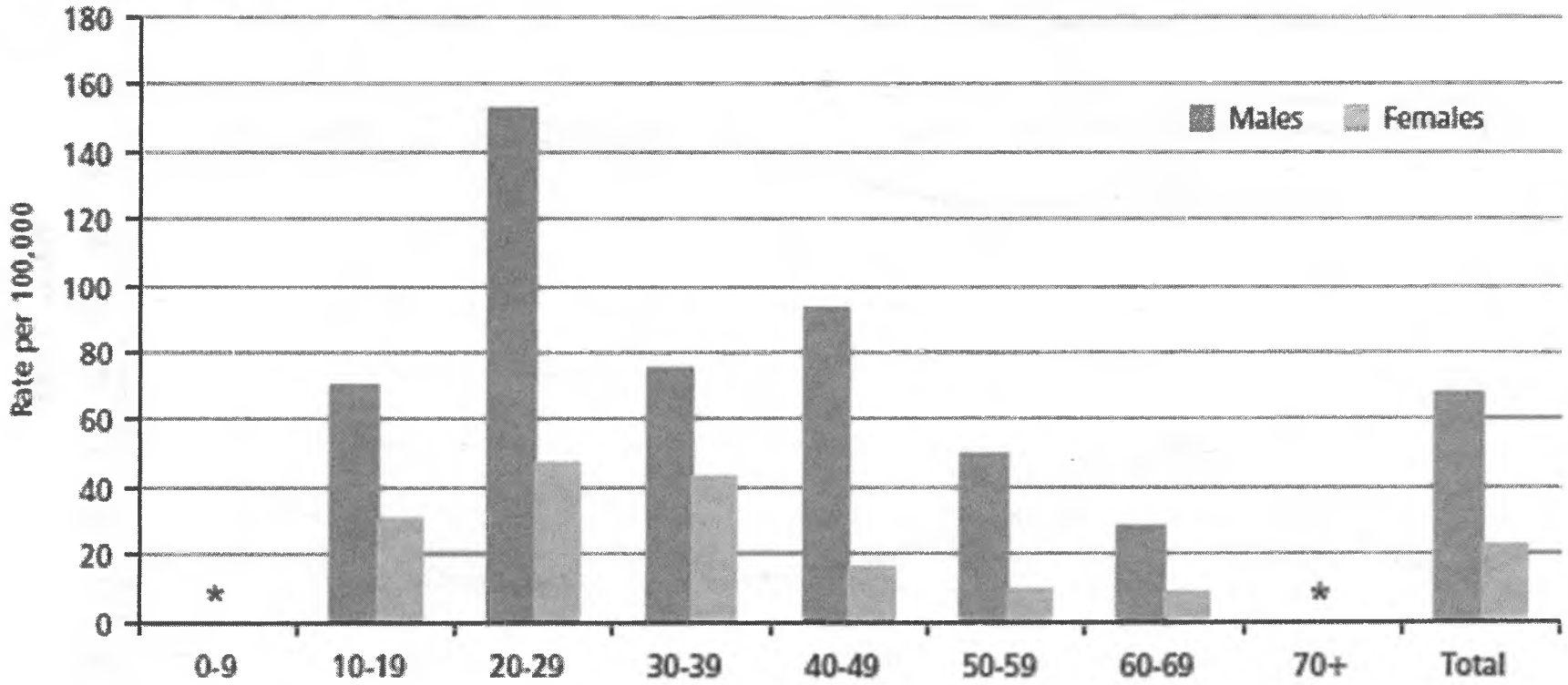
Average Annual Age-Adjusted Suicide Death Rates per 100,000, 1980-2007

Data Source: Alaska Bureau of Vital Statistics
U.S. Data Source: Surveillance, Epidemiology, and End Results (SEER) Program
U.S. Whites and AK Whites 2004-2007 data point is for 2004-2005 only



Average Annual Suicide Death Rates per 100,000 by Age Group and Gender, Alaska Natives, 2004-2007

Data Source: Alaska Bureau of Vital Statistics



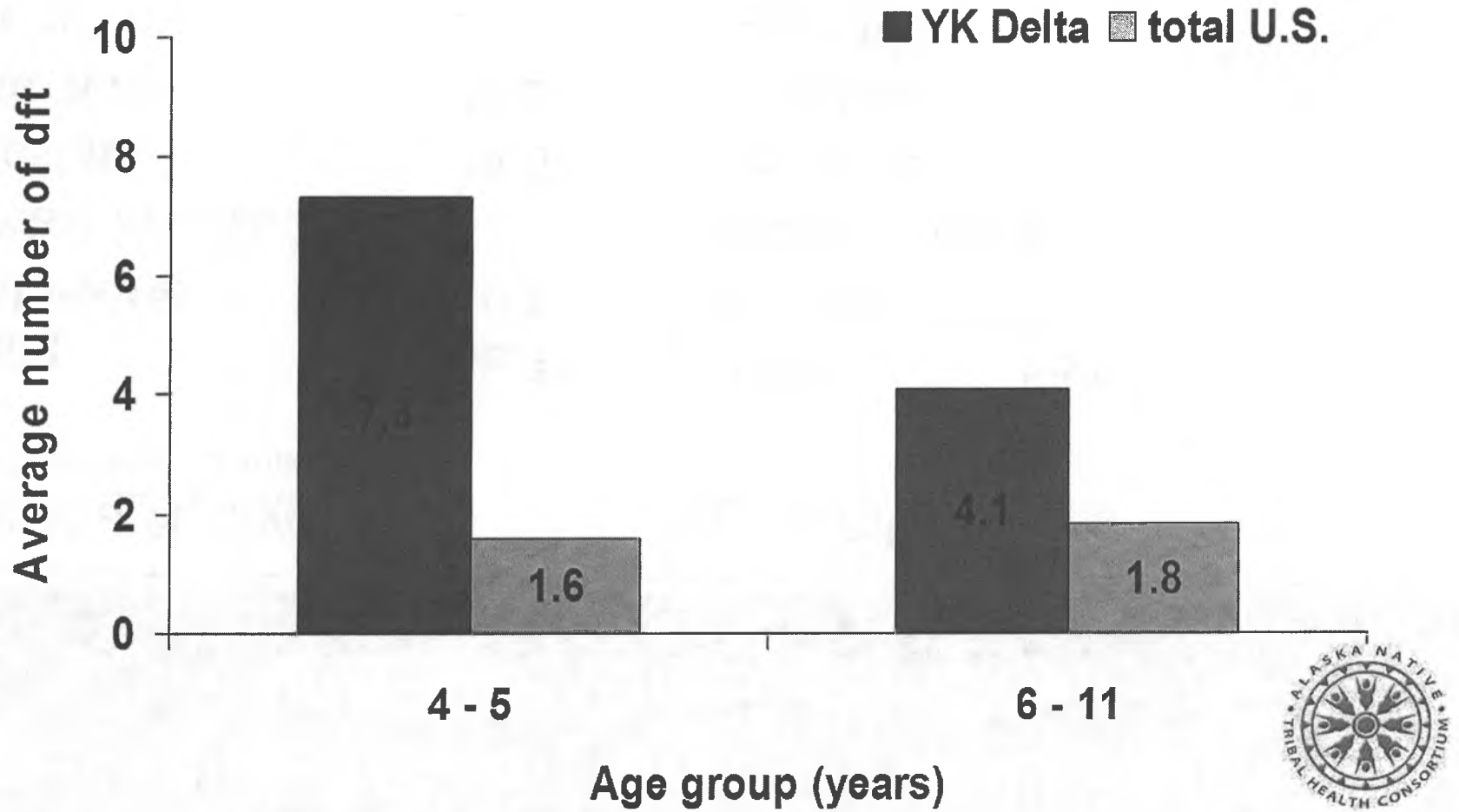
*Less than 3 deaths, no rate calculated

Age-Adjusted Cancer Mortality Rates, 2000-2007
Men and Women Combined

Alaska Native (N=1170 cancer deaths)		US Whites	
Lung	68.3*	Lung	53.9
Colorectal	30.8*	Prostate	24.2
Breast (Female)	24.1	Breast (Female)	24.1
Prostate	18.6	Colorectal	18.0
Pancreas	13.2	Pancreas	10.5
Stomach	12.9*	Leukemia	7.6

* Alaska Native rate is statistically significantly higher than US rate.

Average Number of Dental Caries in Primary Teeth, YK Delta and United States

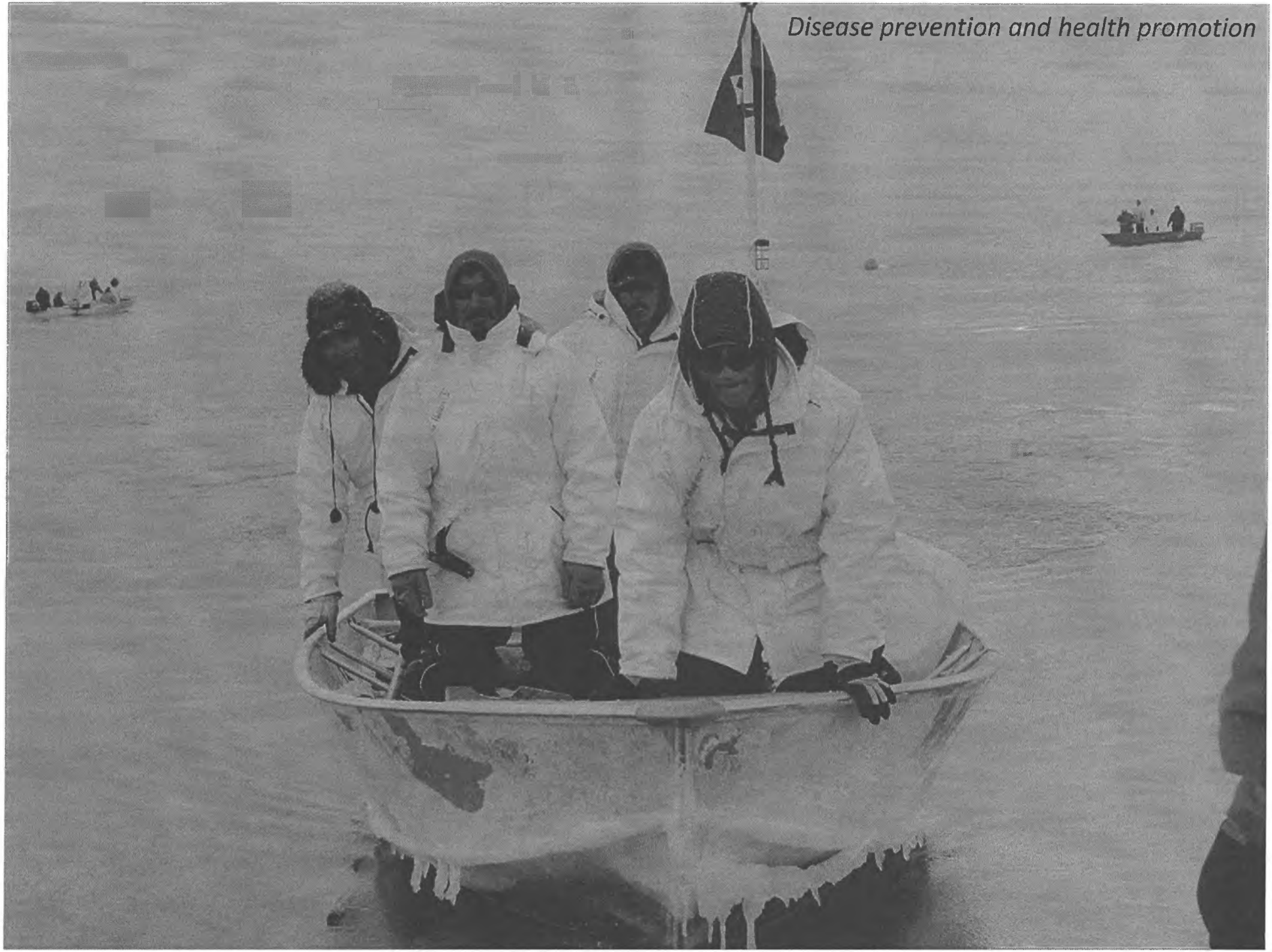


Byrd K, CDC Arctic Investigations Program (2008)

Public Health Challenges of 21st Century

- Unintentional injuries
- Suicide
- Alcohol abuse
- Cancer
- Tobacco
- Diabetes and other complications of obesity
- Oral health


Say "YES"
To a LIFE VEST
SEARCH & RESCUE


Disease prevention and health promotion

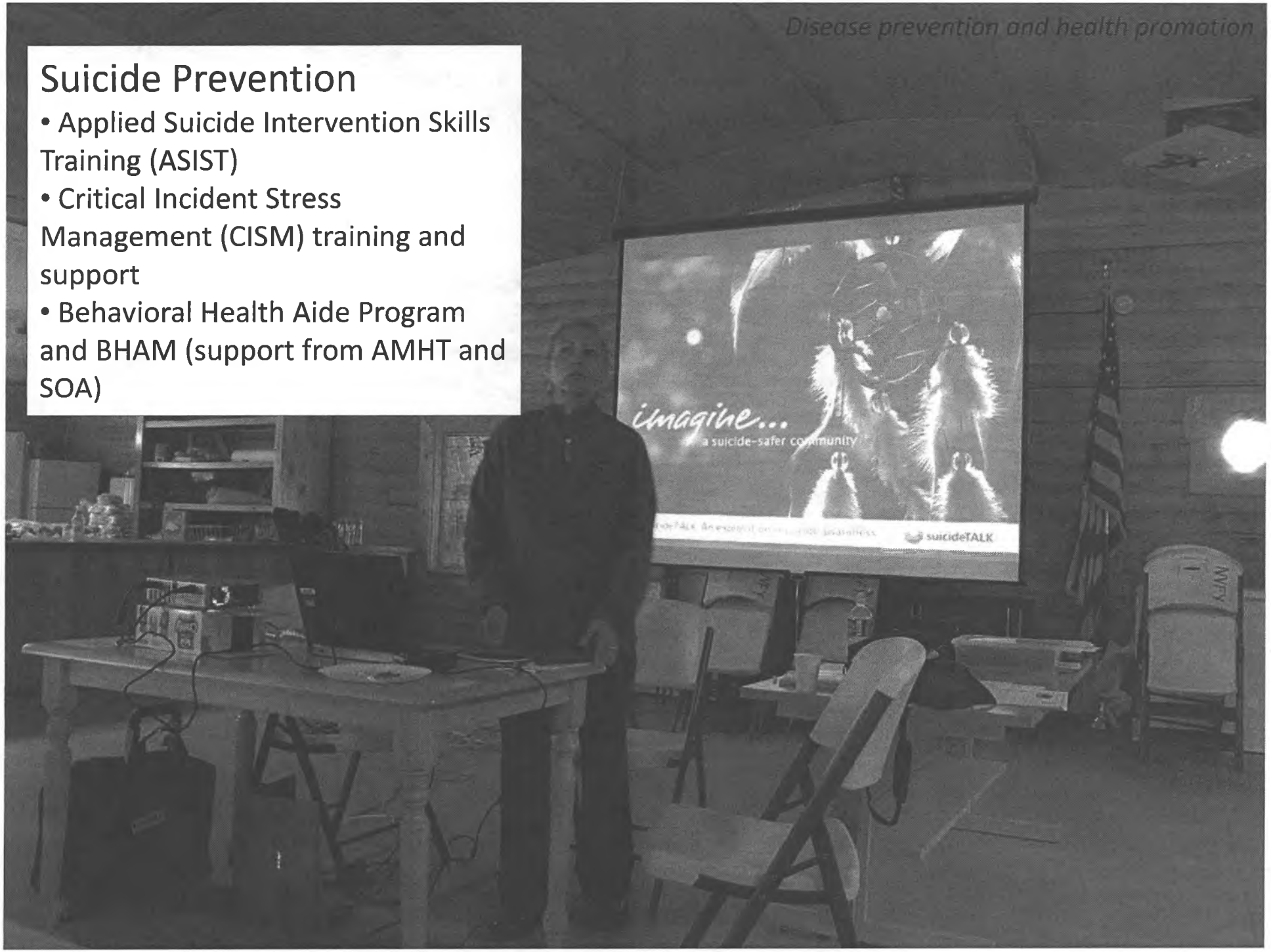
Fall Prevention - Materials

Ice cleats

Home Modification

Suicide Prevention

- Applied Suicide Intervention Skills Training (ASIST)
- Critical Incident Stress Management (CISM) training and support
- Behavioral Health Aide Program and BHAM (support from AMHT and SOA)



ASIST Trainers
Alaska Tribal Health System
3/2011

HELP YOURSELF *to Health*

SCREENING EXAMS TO PREVENT CANCER OR FIND CHANGES EARLY

Disease prevention and health promotion

PATHWAYS *For Health*

include having screening exams when you are healthy to stay healthy.

Talk with your health care provider to learn what screening exams are best for you, at what age to begin screening and how often.

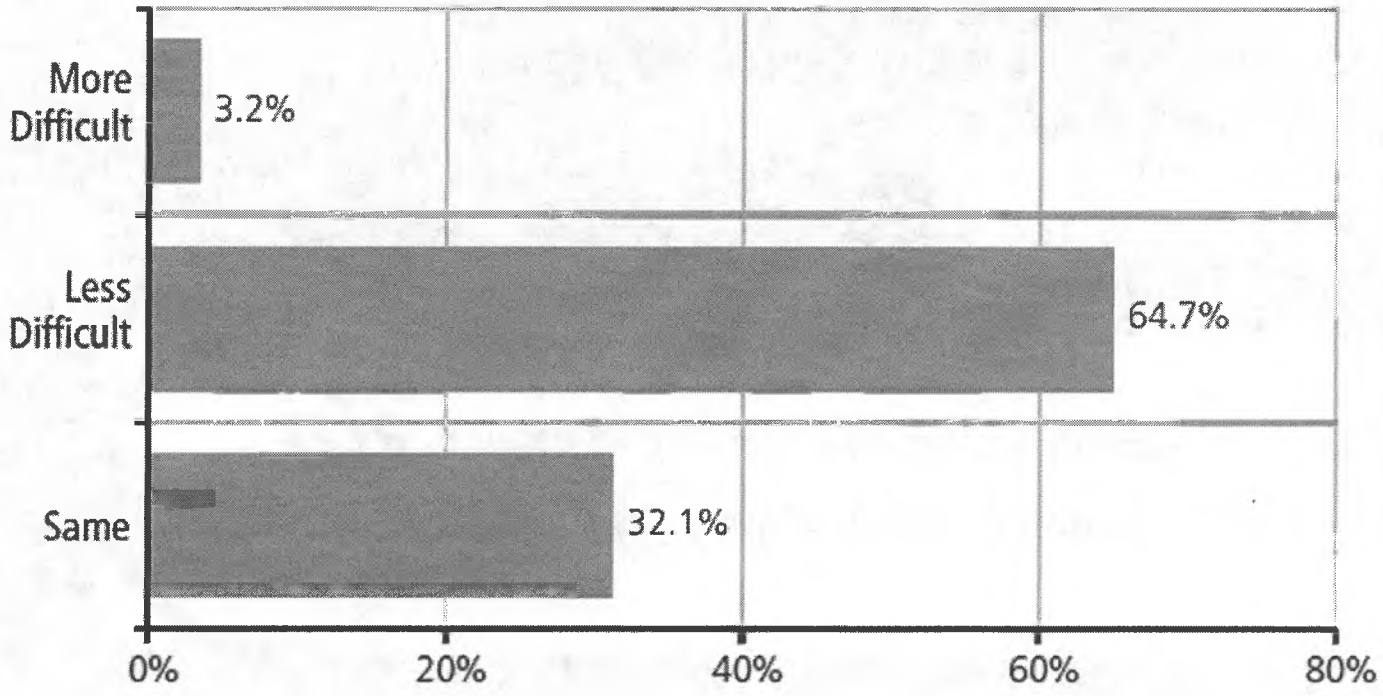
Wellness choices include living in ways that support physical, emotional, mental, social, and spiritual wholeness.

Cancer Screening and Prevention

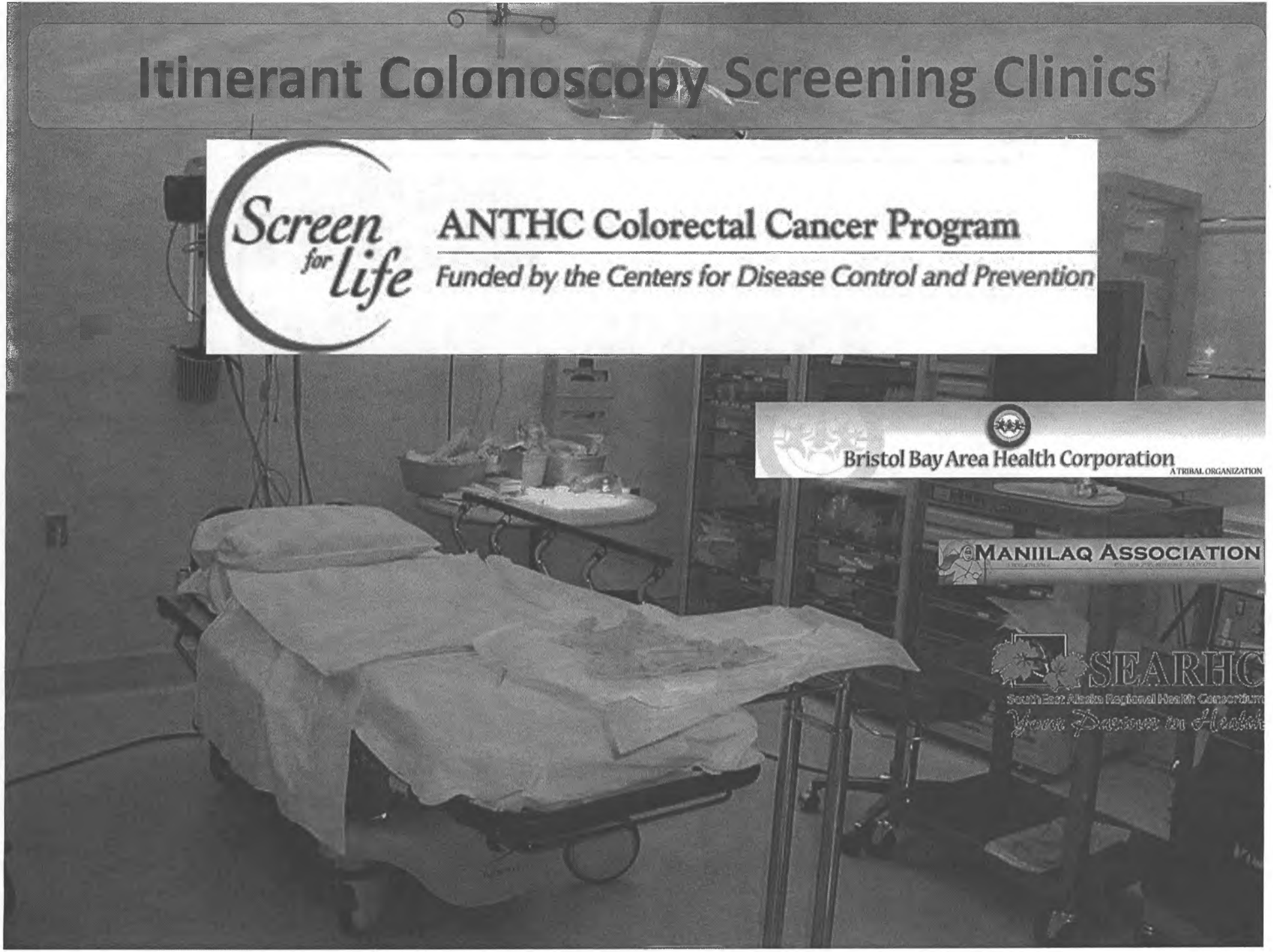
Nolan the Colon

Survey of ATHS Tribal Leaders and Providers

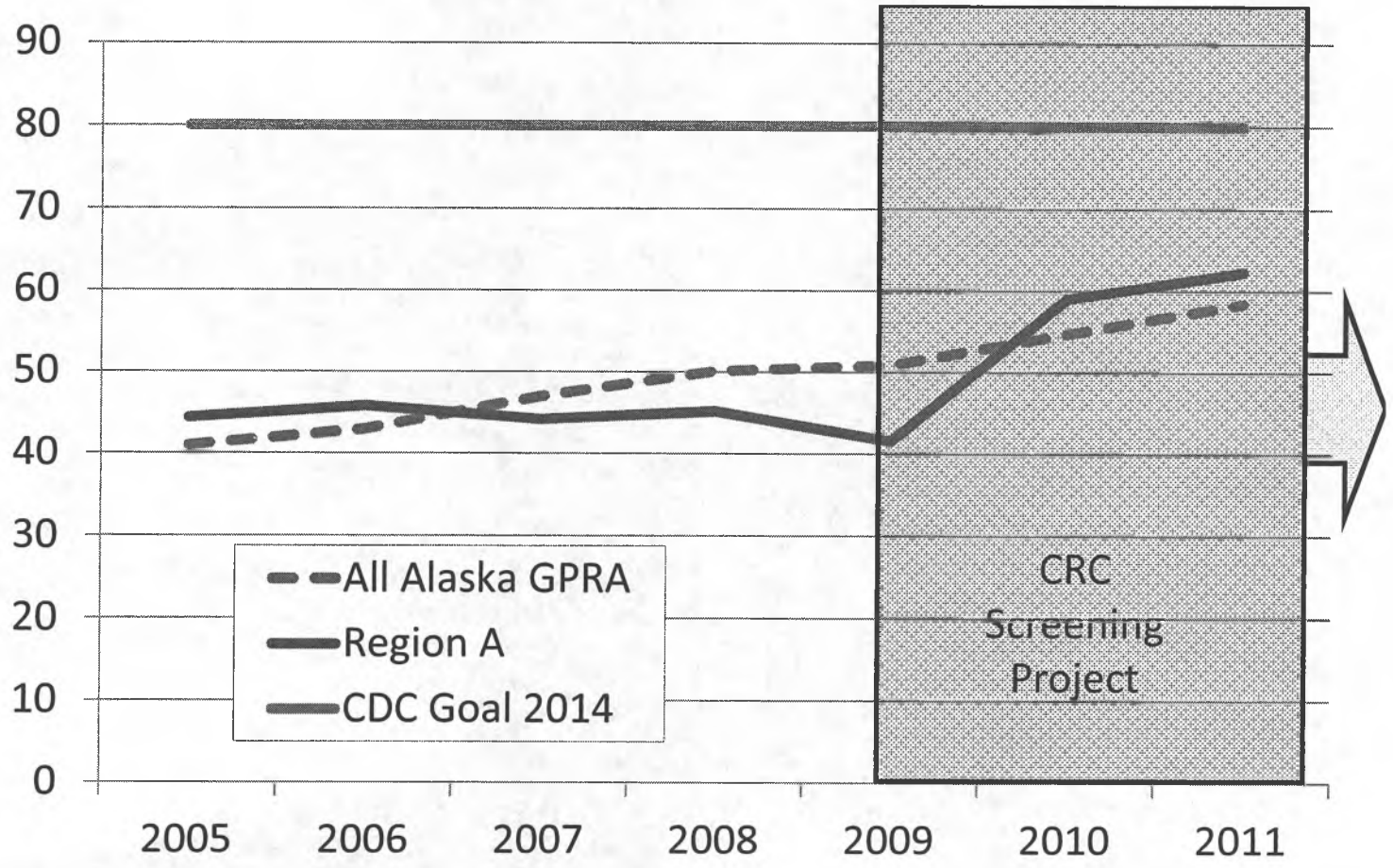
Do you believe that cancer is more or less difficult to talk about than it was five years ago? N=216



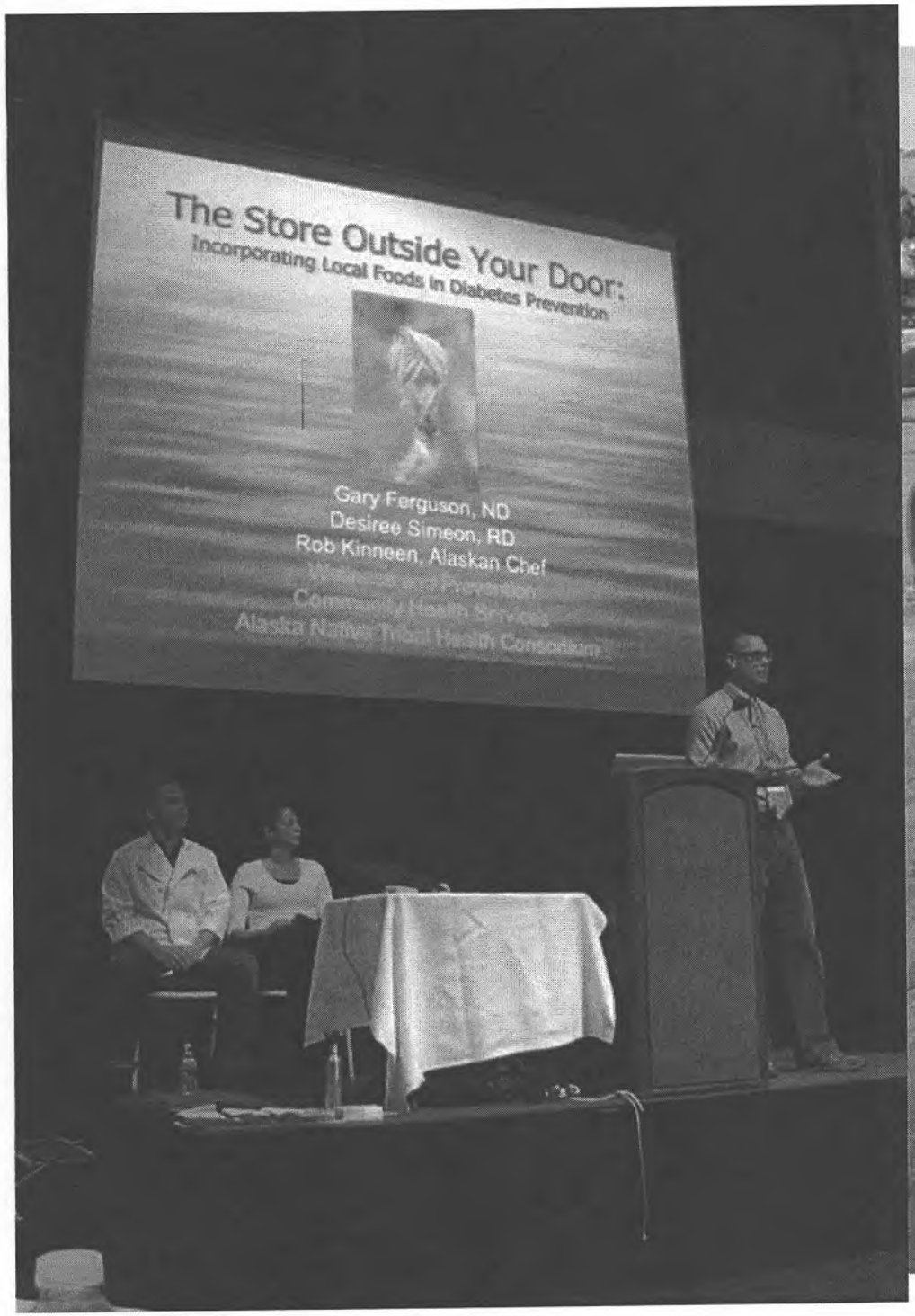
Itinerant Colonoscopy Screening Clinics

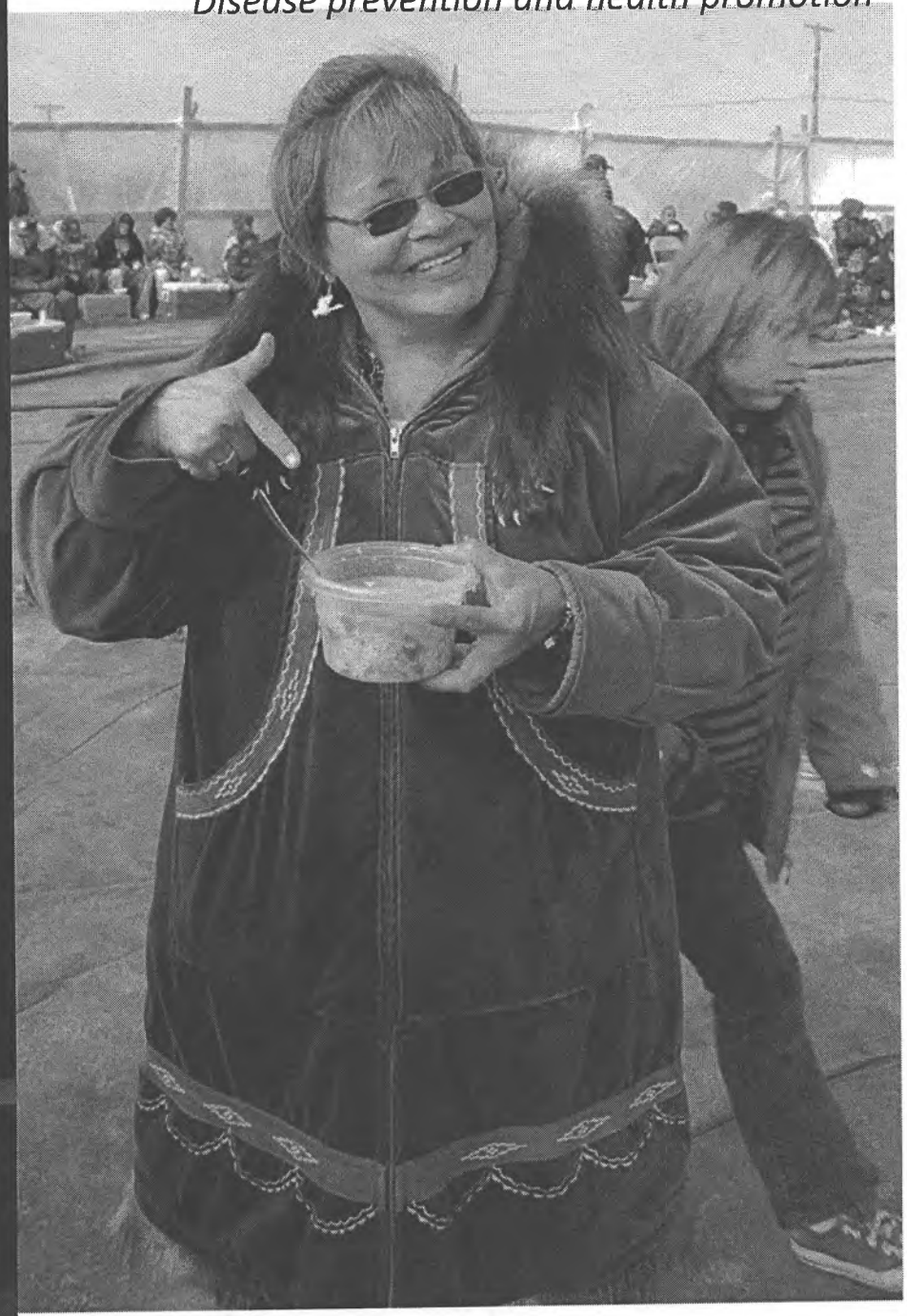


Colorectal Cancer Screening Rates, 2005-11



Disease prevention and health promotion

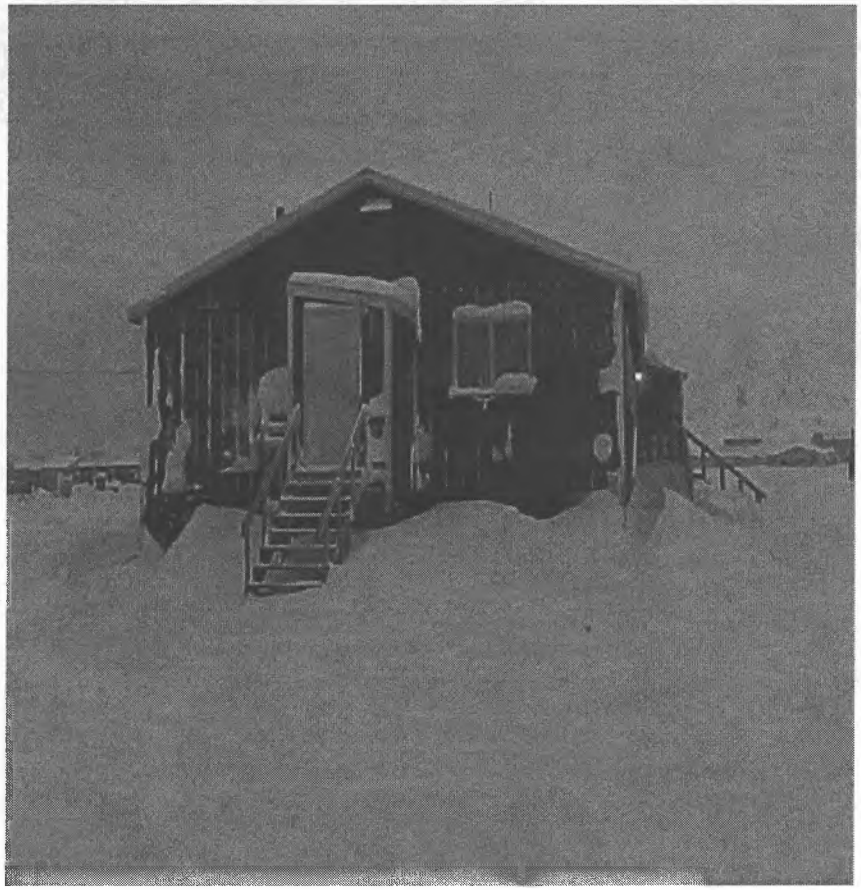




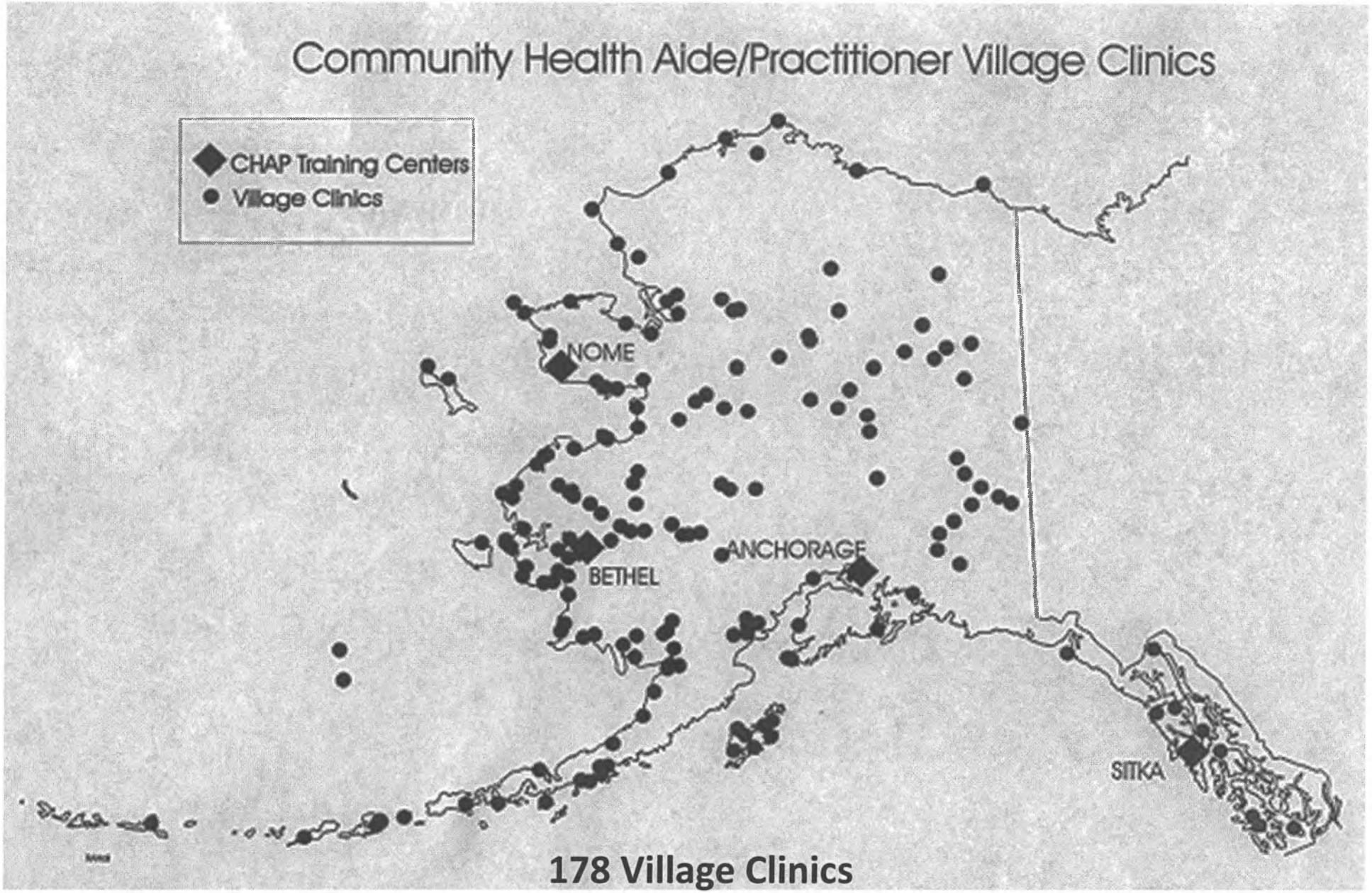
Health Care Provider Training

- Community Health Aides
- Behavioral Health Aides
- Dental Health Aides

CHAP History



- 1950s: TB Chemotherapy Aides
- 1960s: Formal Training/Federal Funding
- 1980s: 200 CHA/Ps in 150 villages
- 2000s:
  - Behavioral Health Aides
  - Dental Health Aide Therapists



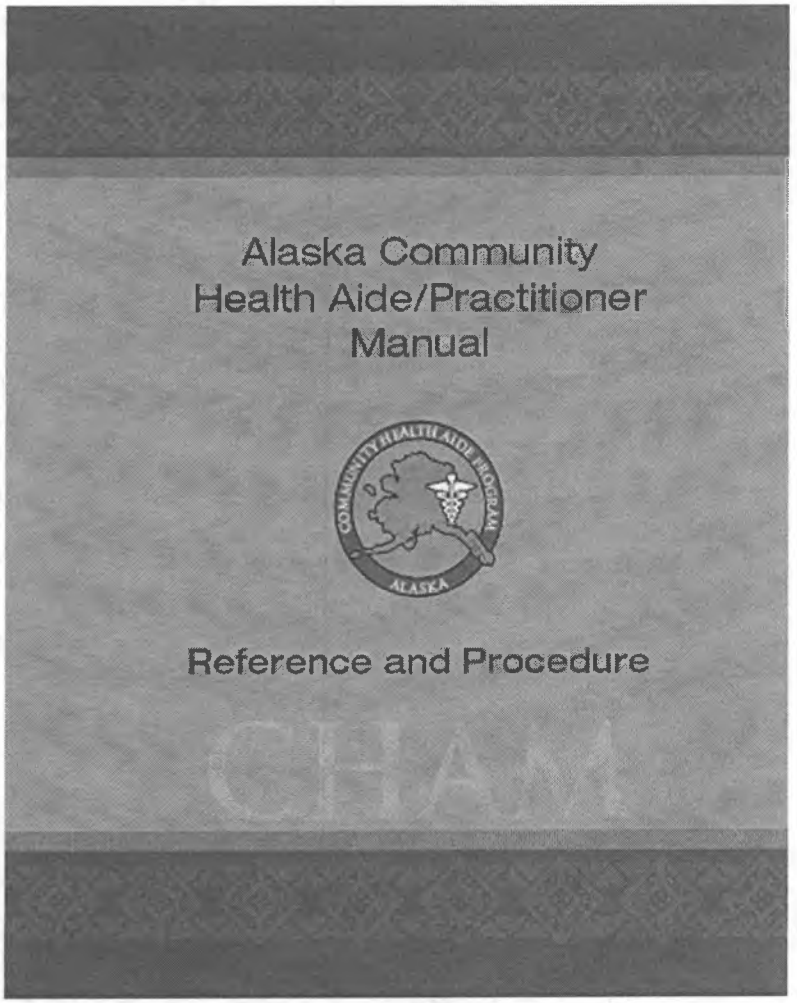
178 Village Clinics

550 Community Health Aides/Practitioners

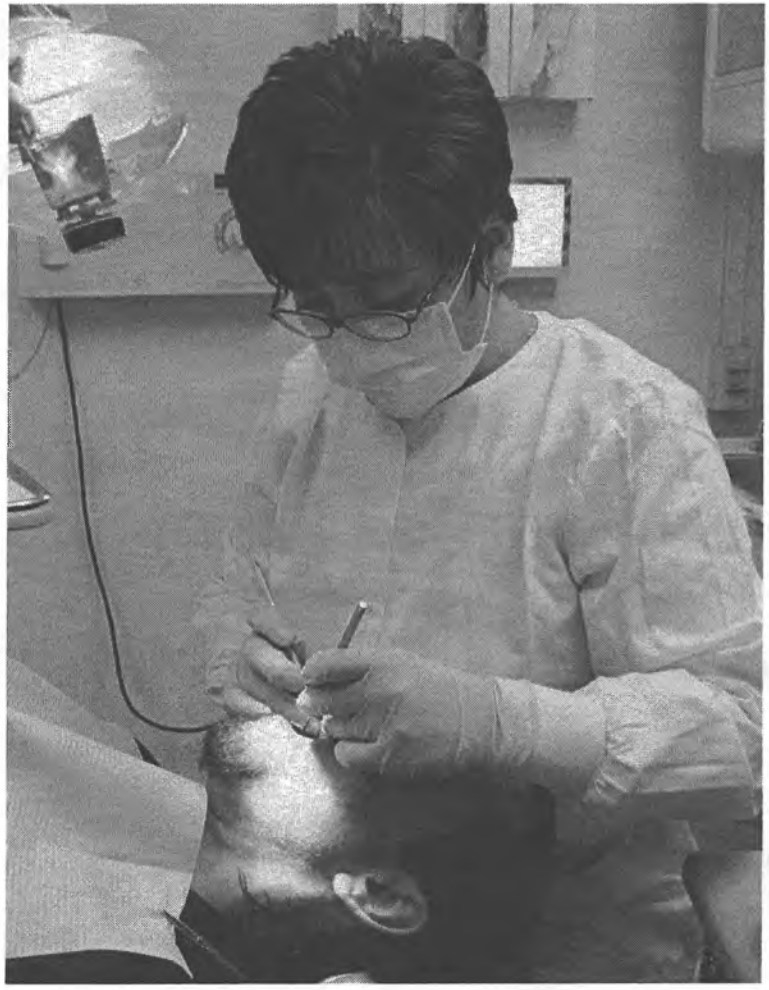
270,000 Patient Encounters

Alaska Community Health Aide/Practitioner Manual (CHAM)

- A guide to the CHA/P for every patient encounter
- 6th grade reading level
- Multiple cross references
- Current treatment guidelines based on "best practices" as agreed upon by panel of medical reviewers



Dental Health Aide Therapist Program

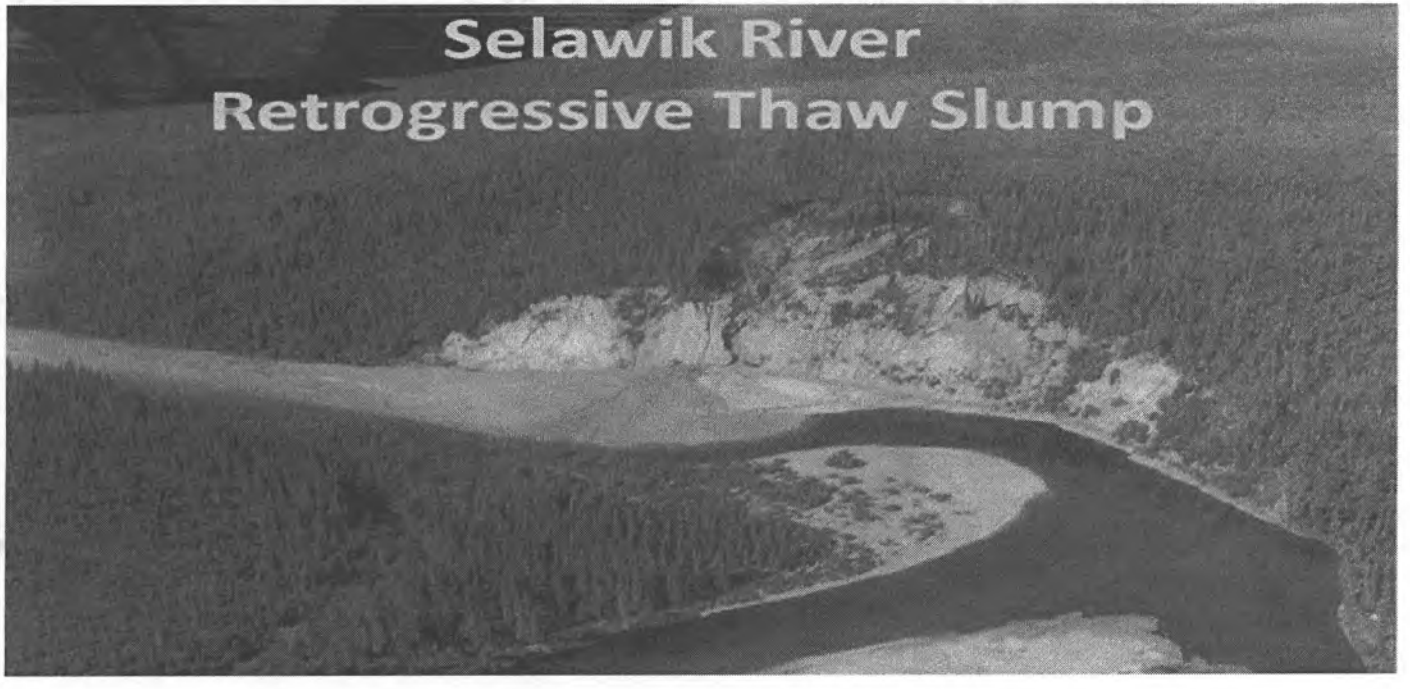


Health Research Topics

- Cancer screening and early diagnosis
- Tobacco cessation and nicotine metabolism
- Oral health
- Hepatitis
- Auto-immune diseases
- Immunology and infectious disease prevention (in partnership with CDC Arctic Investigations Program)

Technical assistance and statewide subspecialty care

- HIV Clinical Care and Hepatitis Clinic
- HIV & STI Prevention
- Cancer Program Planning & Development
- Assessment of the Impact of Arctic Warming



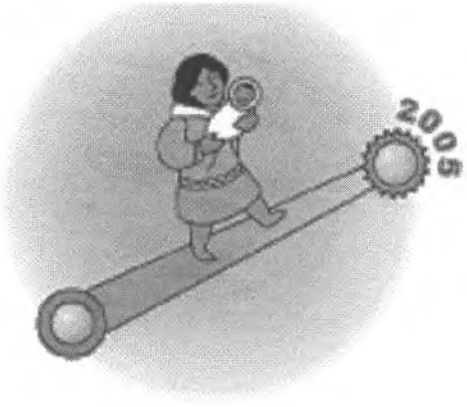
Public Health Performance Improvement: CDC NPHII Program

- Process Improvement
  - ANTHC Tobacco Cessation Program
  - Grant management
- Data dissemination and community engagement
- Public health accreditation

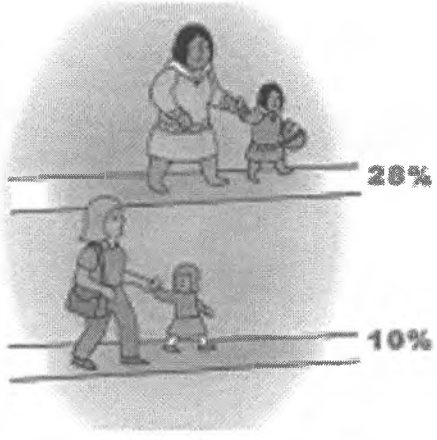
Our Vision

Alaska Natives are the healthiest people in the world

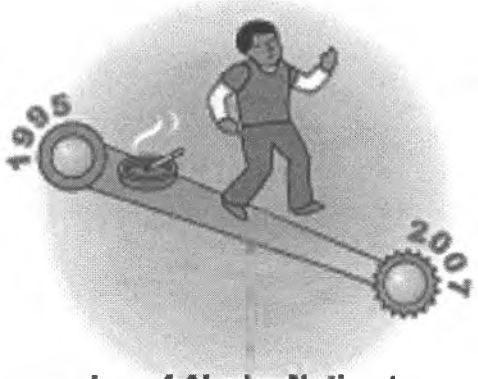
Progress Towards the Vision…



In 2005, 90% of Alaska Native women chose to breastfeed their babies at birth. More mothers are breastfeeding now than 10 years ago.[2] We need to keep this tradition strong!



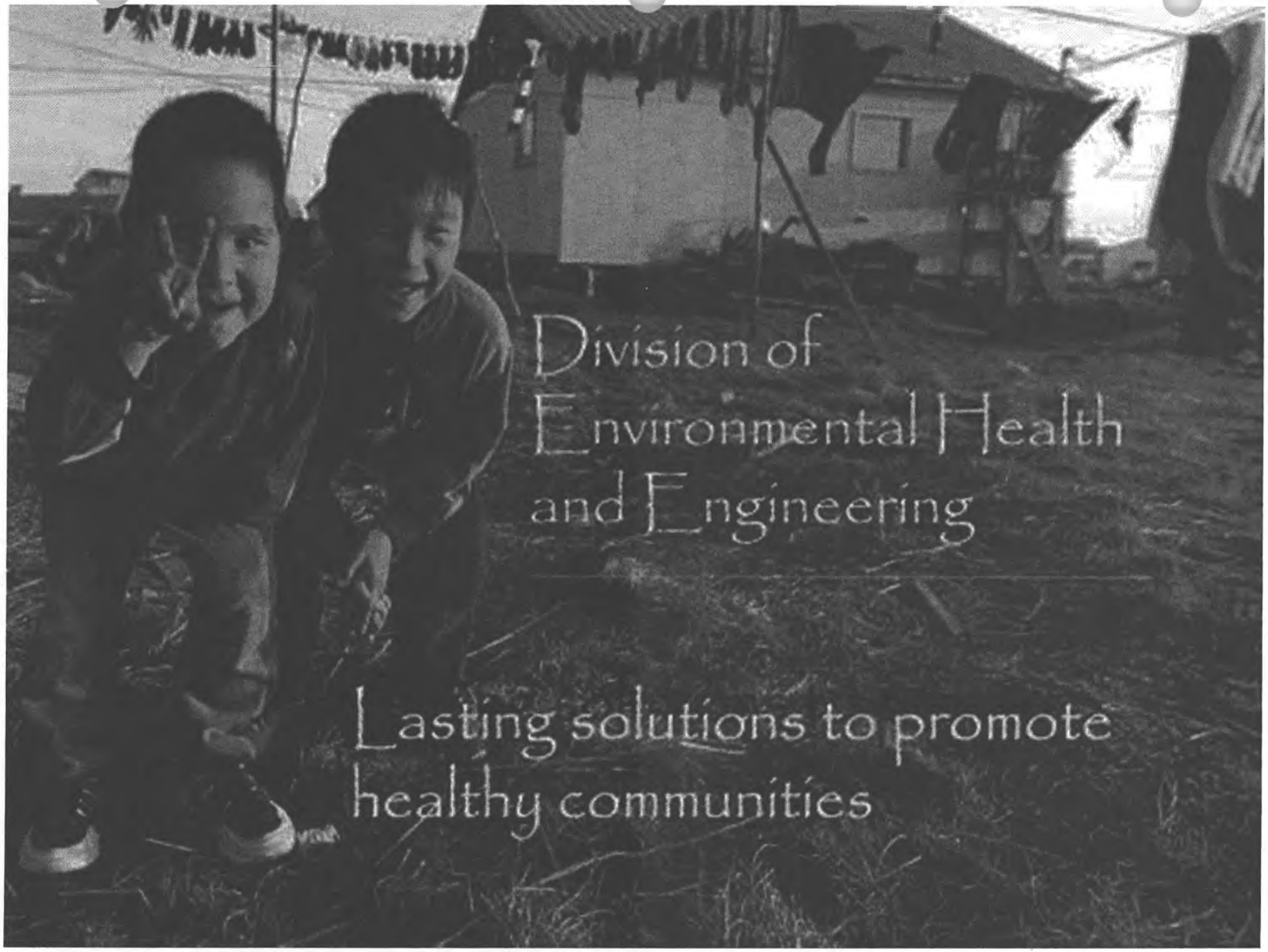
The number of Alaska Native mothers who report exercising everyday is almost three times higher than non-Native mothers. (2004)



The number of Alaska Native teens who smoke has gone down 30% since 1995.

In fact, there has been a 68% decrease in the number of Alaska Native people who have drowned, and a 71% decrease in the number of people who have died in a fire.

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM


Division of
Environmental Health
and Engineering
Lasting solutions to promote
healthy communities

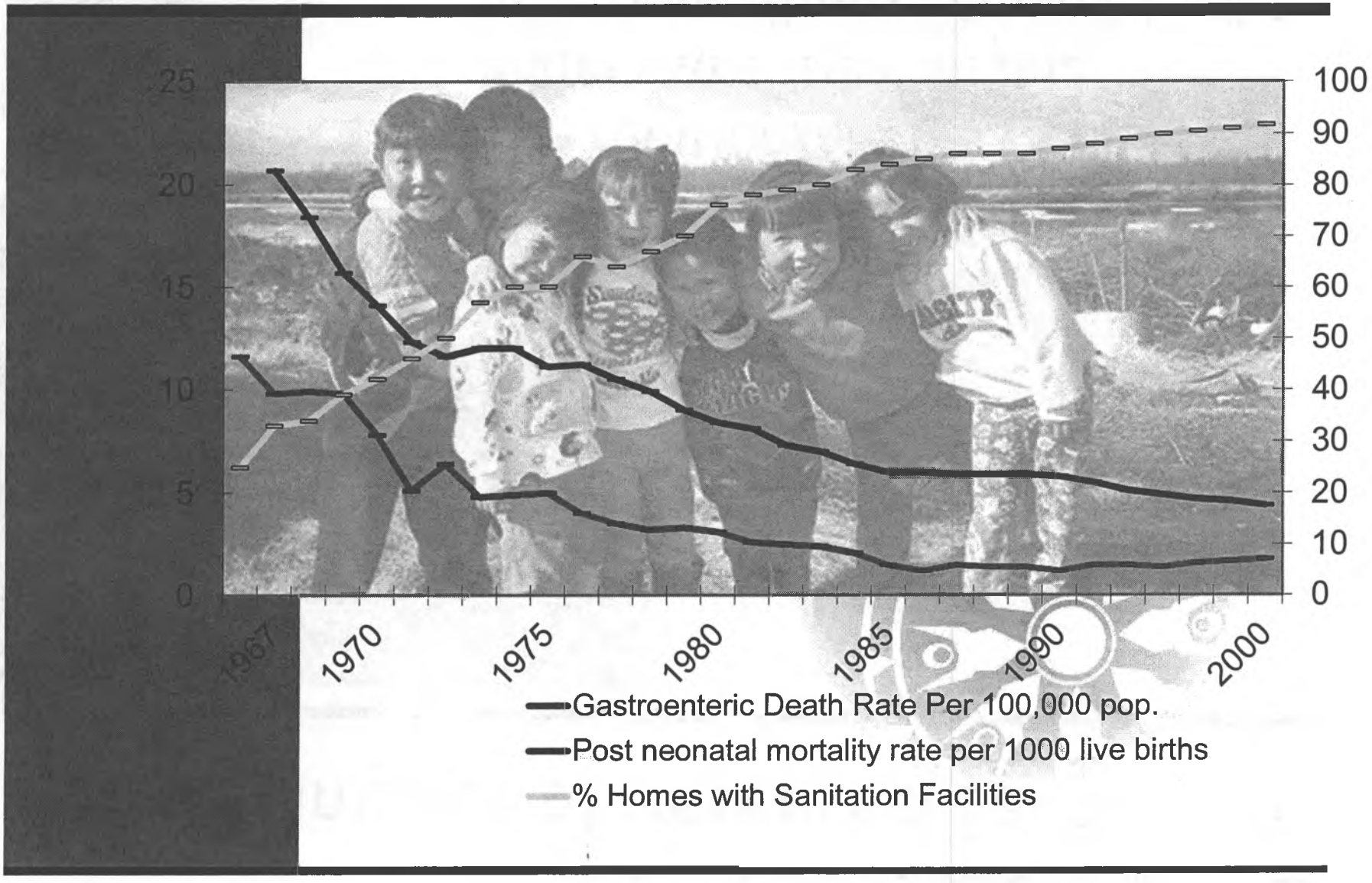
Overview

- Health impact of improved sanitation
- ANTHC/DEHE - Public Health Services
- Recent project successes
- Capital funding for sanitation
- Focus for future efforts: Sustaining the investment in rural Alaska

Health Impact of Improved Sanitation

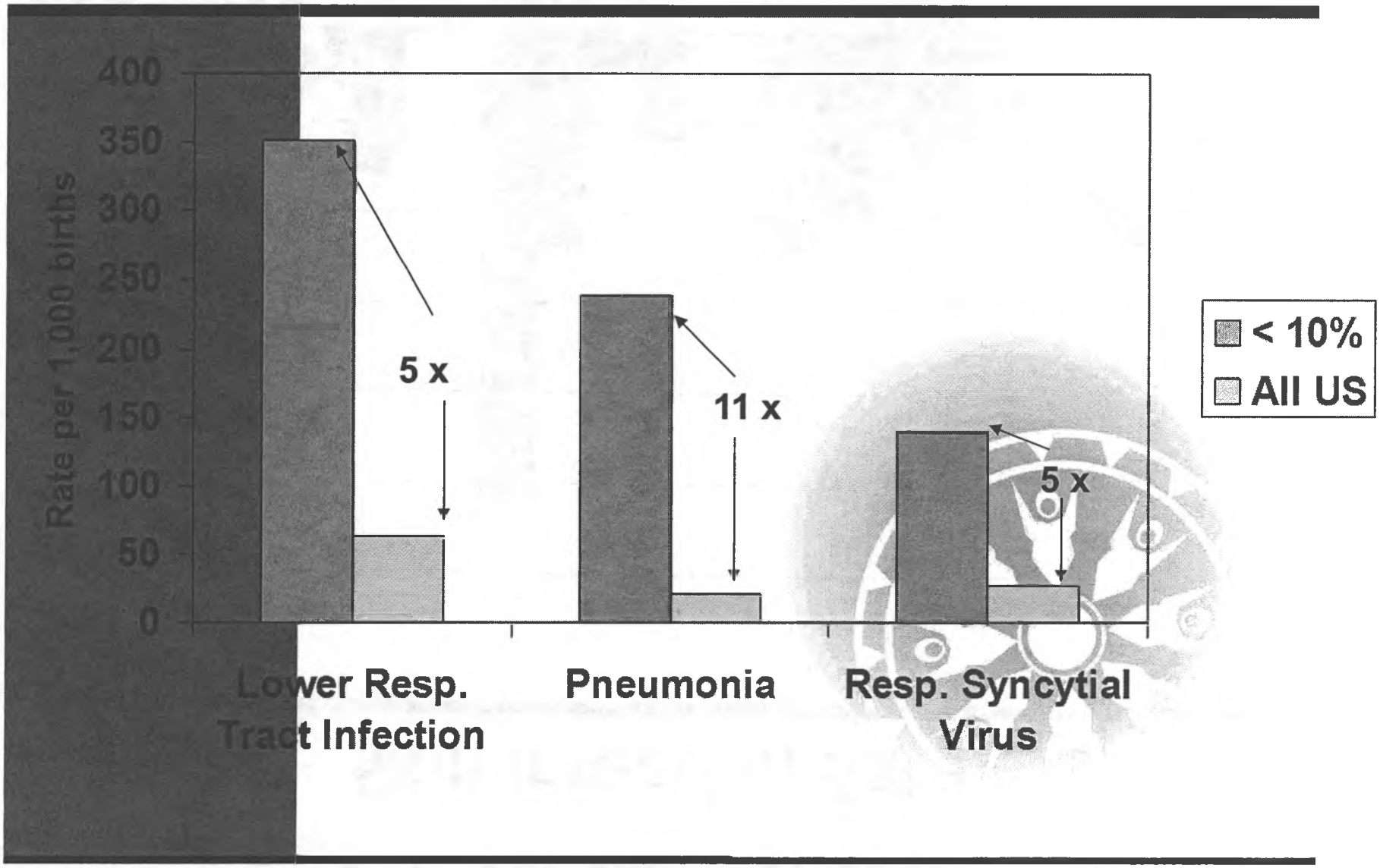
The relationship between in-home water service and infectious disease among Alaska Natives

Gastrointestinal and postneonatal* mortality rates compared with percent of American Indian and Alaska Native homes having sanitation facilities

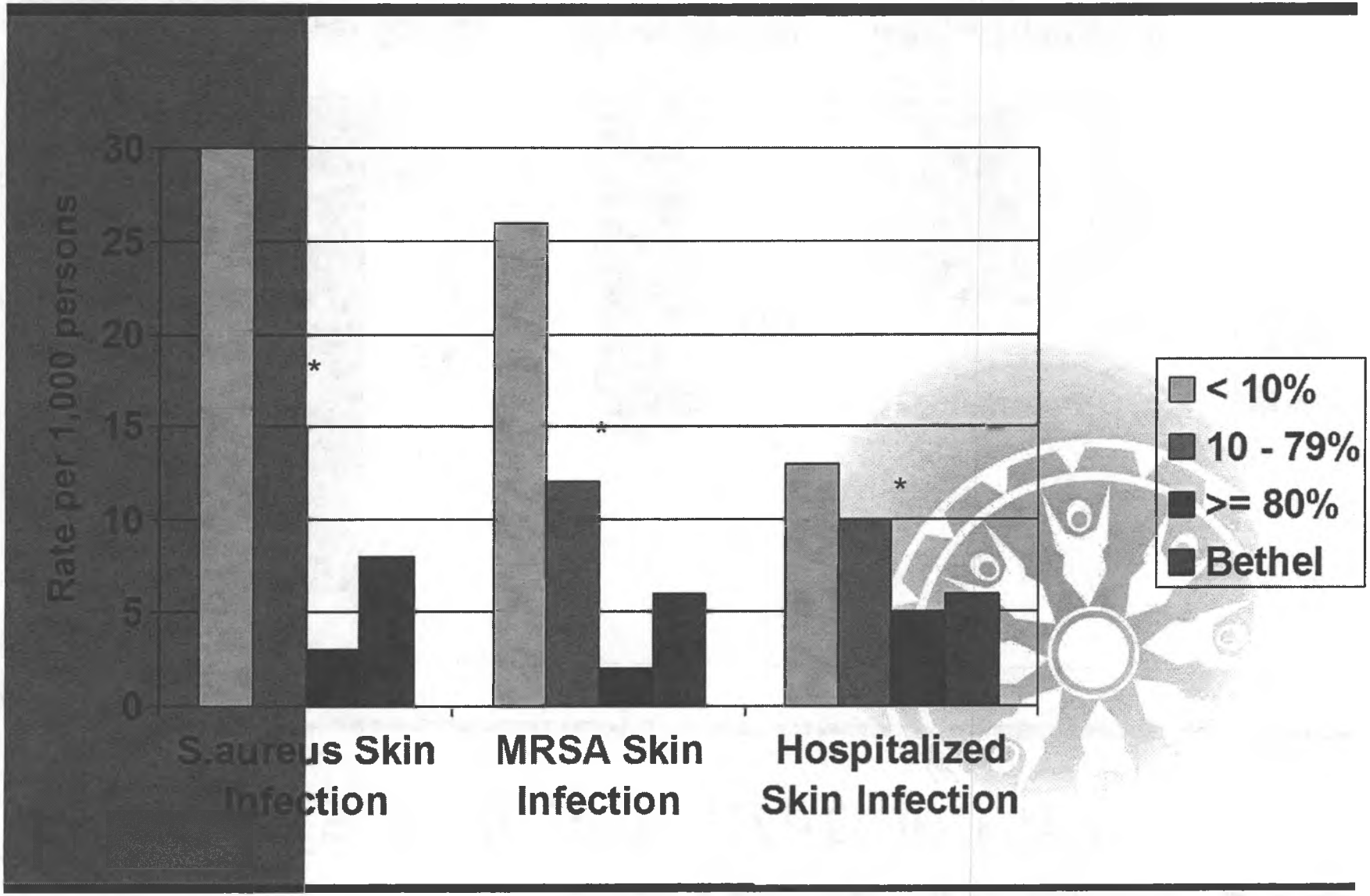


* 29 days to one year of age

Infant Hospitalization Rate



Skin Infection Rate



Impact of Improved Sanitation

- 67% reduction in diarrheal morbidity
- 58% fewer clinic visits from sanitation-related disease
- 55% reduction in overall child mortality

ANTHC/DEHE - Public Health Services

Facilities Operations

- Public health facility planning, design & construction (clinics, water and sewer)
- Support Regional Hospital Operations

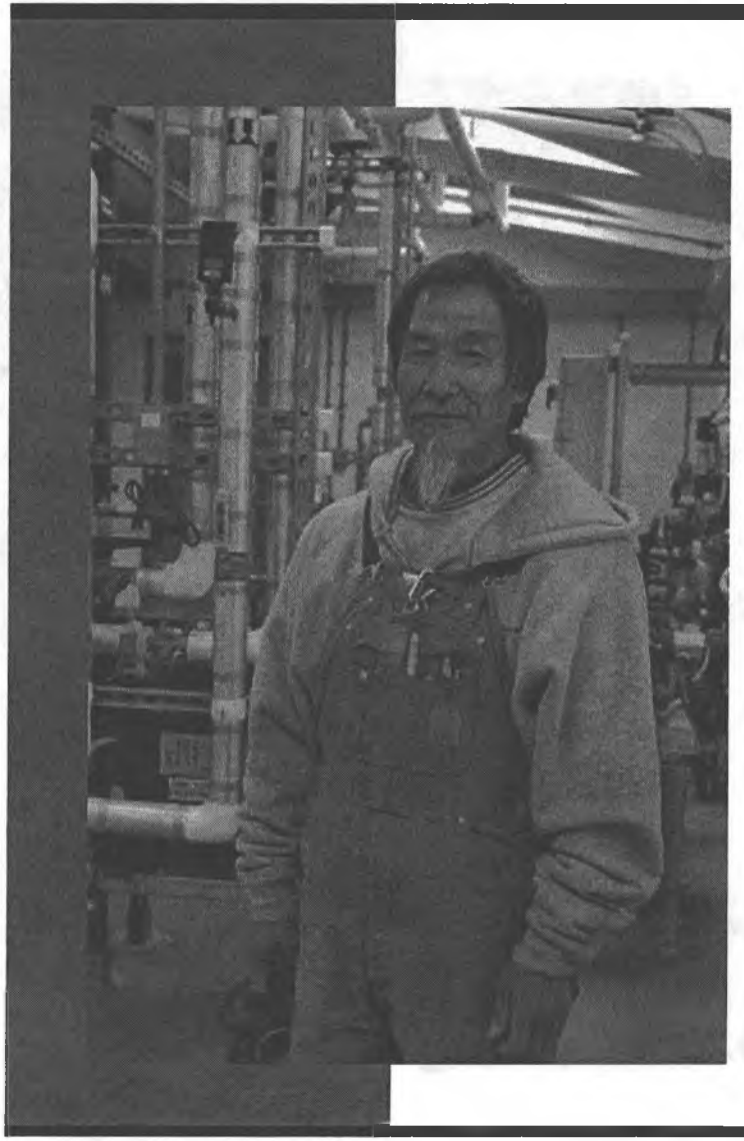
Environmental Health Support

- Community environmental health
- Institutional environmental health

Tribal Utility Support

- Utility technical support
- Utility operations
- Public works jobs training

DEHE: Organization Profile



DEHE employs approximately 250 staff members

60 tradesmen working in rural Alaska

582 Local hire, village force account laborers

Program Partners and Funding Agencies

- State of Alaska
- U.S. Environmental Protection Agency
- U.S. Indian Health Service
- USDA Rural Development
- Denali Commission

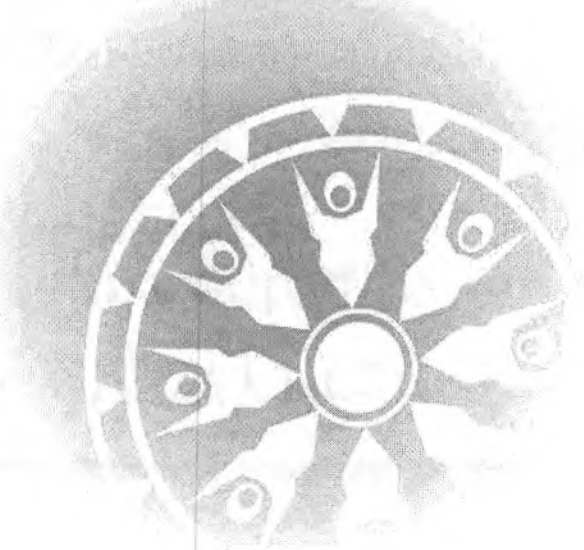
Coordination amongst agencies is critical!

Program Partner - State of Alaska

- Village Safe Water (VSW) Program
  - Communities are represented by an ANTHC or VSW engineer
  - Coordinate funding Agency requirements
  - Provides a match to federal funding
- Municipal Grants and Loans
- Remote Maintenance Worker Program

Recent Project Successes

- On-going planning, design, or construction in approximately 60 communities statewide
- Recently completed first-service:
  - Akiak (90 homes)
  - Chuathbaluk (28)
  - Fort Yukon (246)
  - Goodnews Bay (76)
  - Kasigluk (75)
  - Kwigillingok (87)
  - Nunam Iqua (43)
  - Pilot Point (35)
  - Pitkas Point (31)



Rural Sanitation in Alaska

- Nearly 1/5 of all rural homes do not have adequate sanitation facilities
- There is a $740M unmet need in Alaska

Un-served Communities (43)

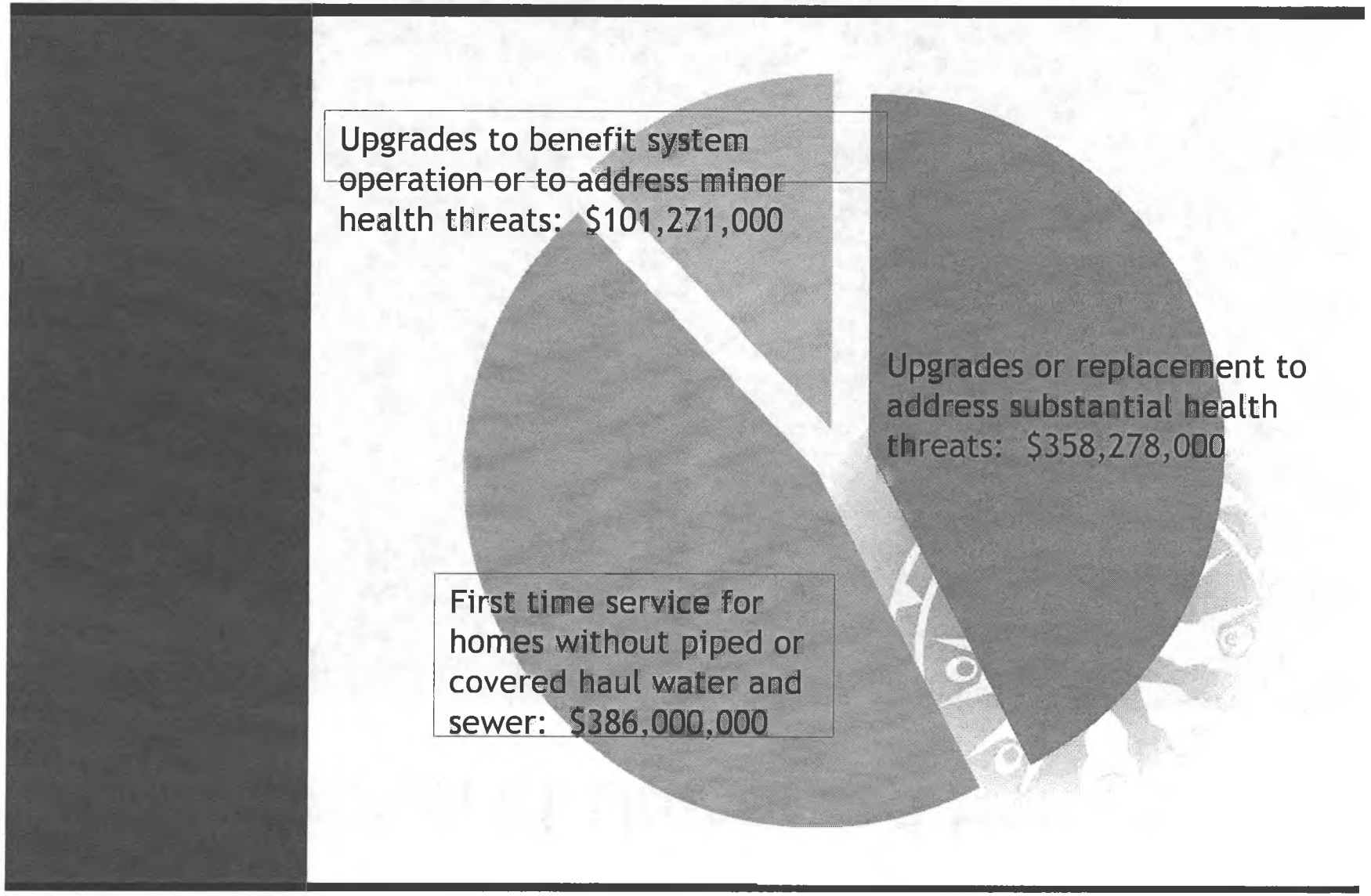
- 11 are have funded systems and are being constructed
- 15 are served with a washeteria
- 17 do not have approved plans

Approximately 6,000 homes remain un-served

Honey-Bucket Haul

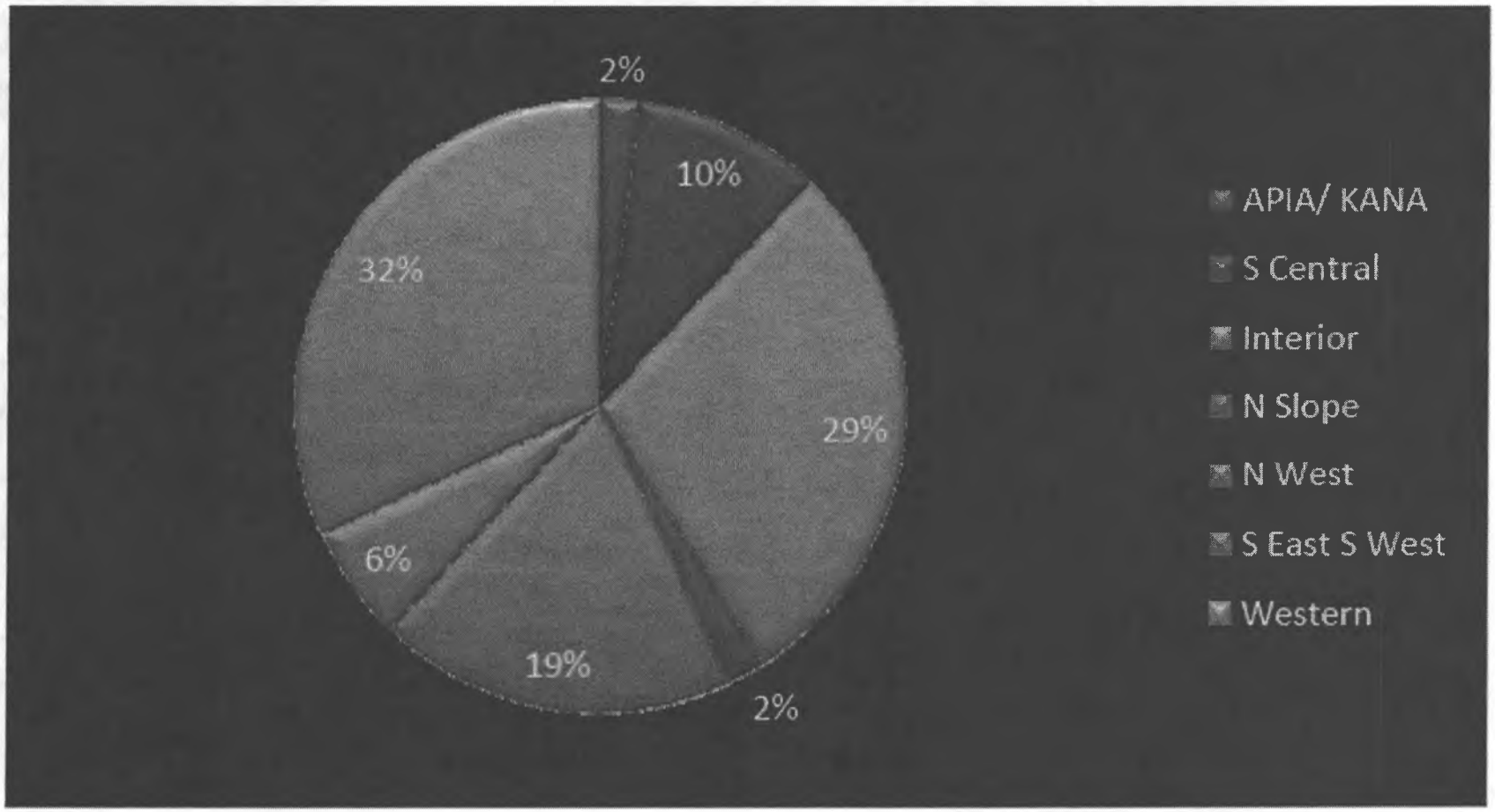
Basic Honeybucket disposal and personal hygiene in Atmautluak

Types of Sanitation Needs



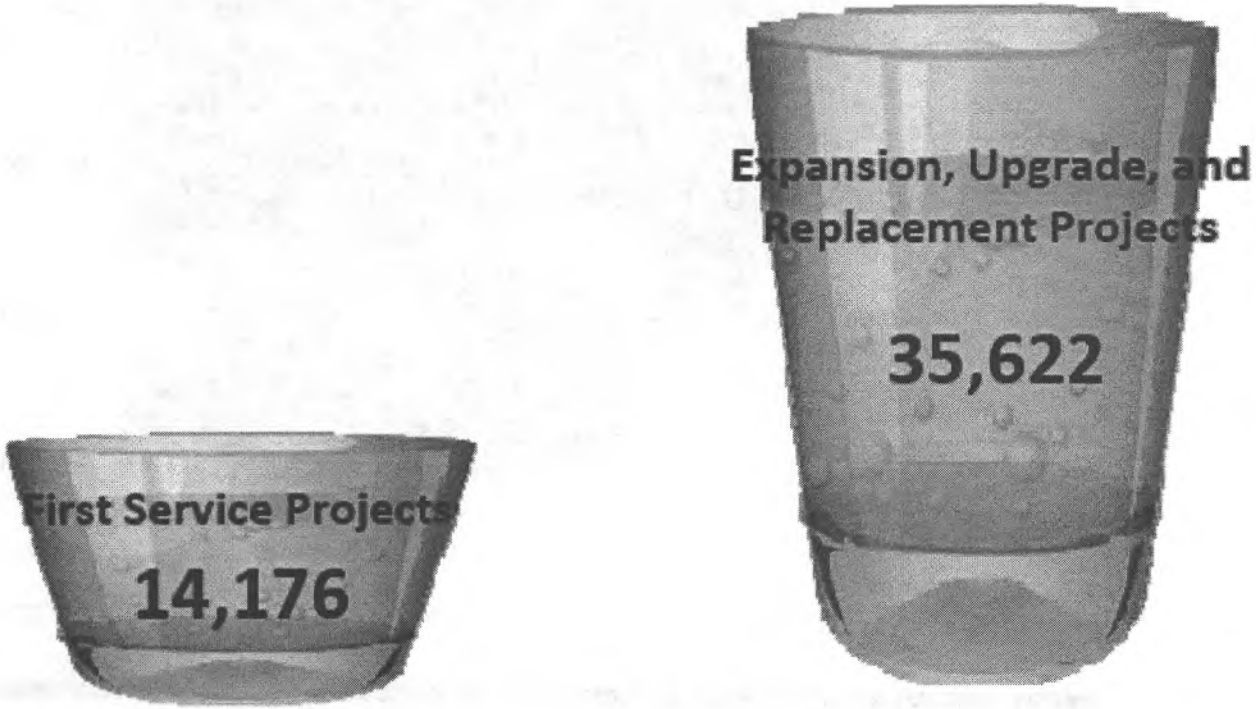
*Data provided by the State of Alaska

Location of Un-served Homes



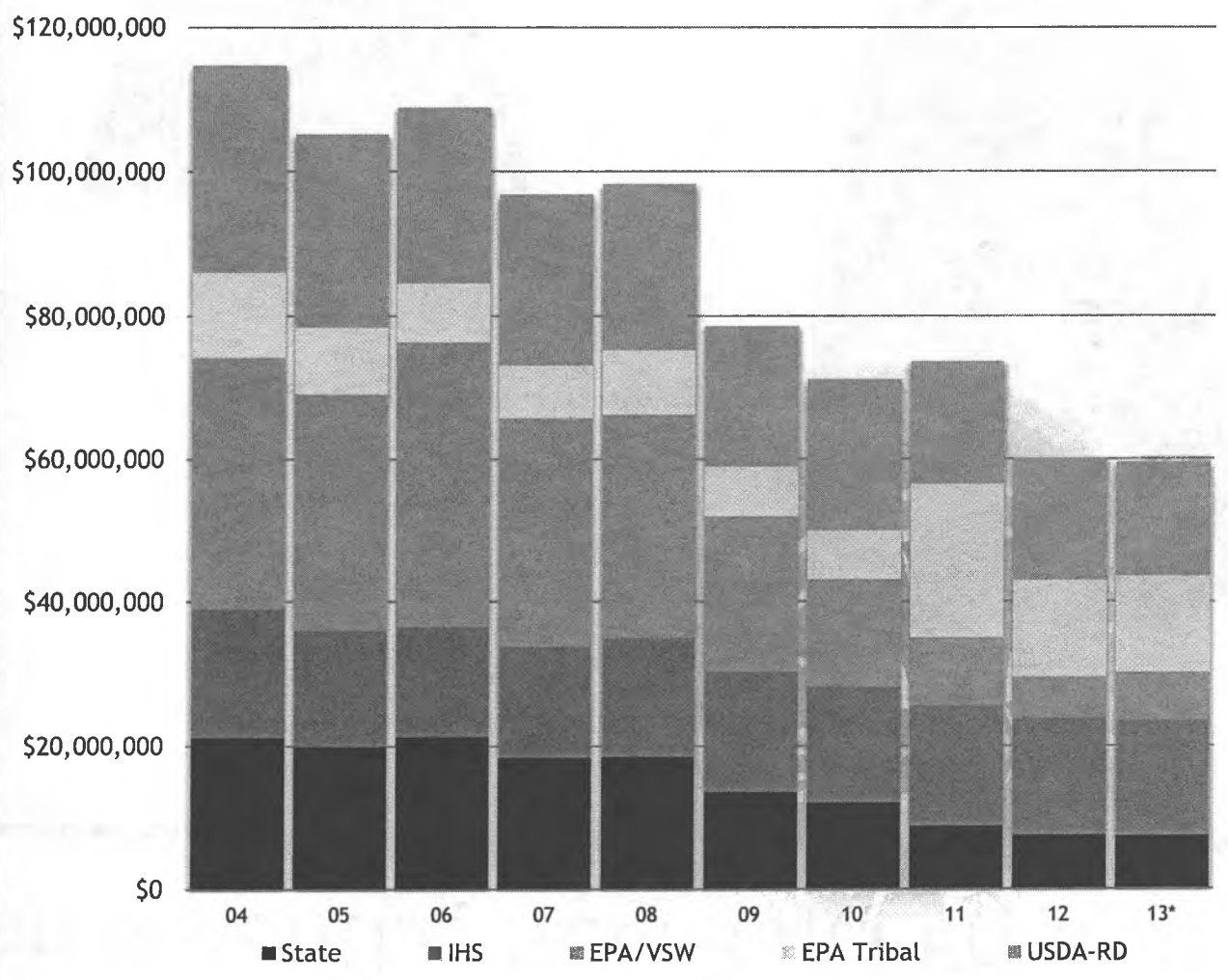
*Data provided by the State of Alaska

Population Benefiting from Rural Projects



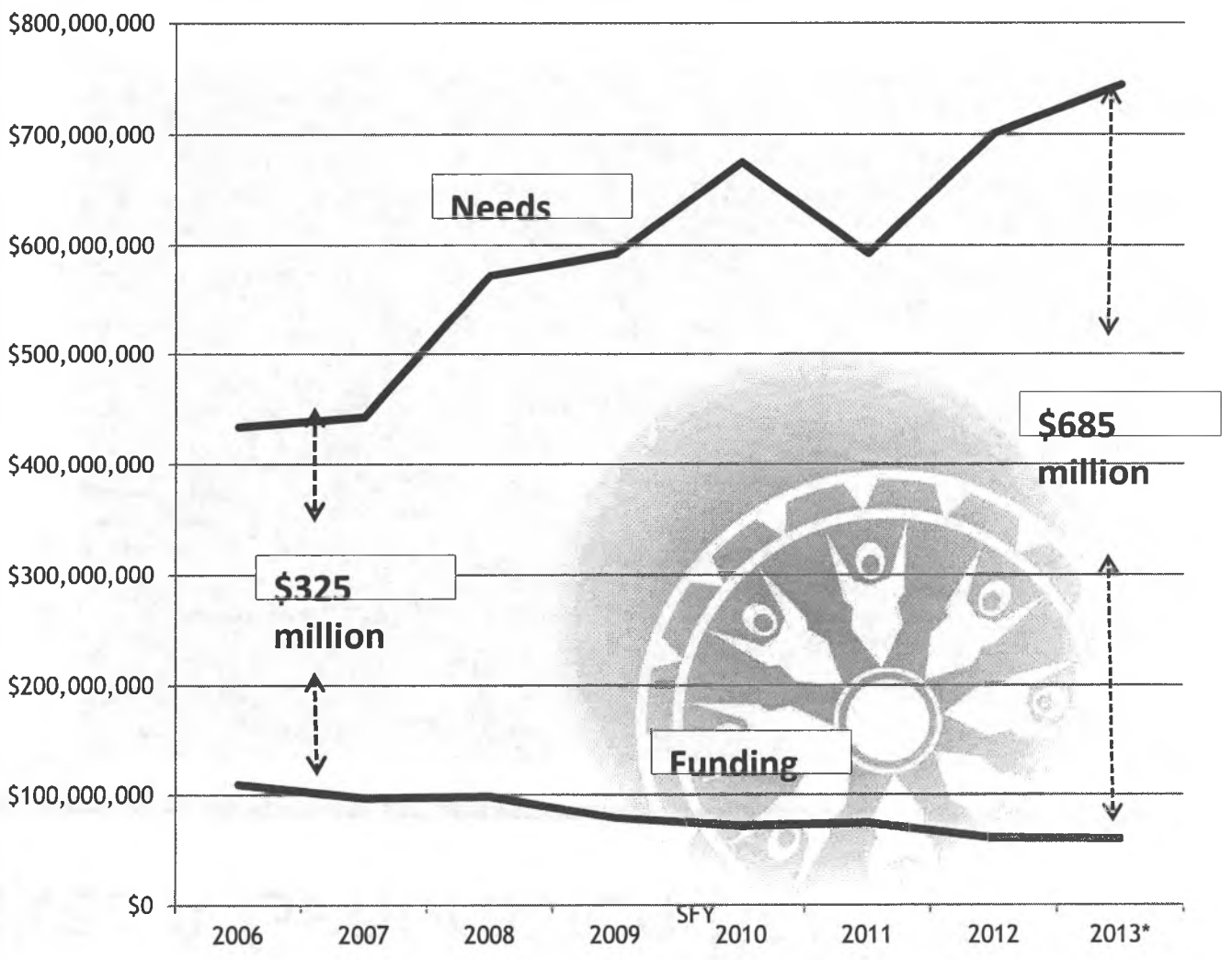
*Data provided by the State of Alaska

Capital Funding for Sanitation



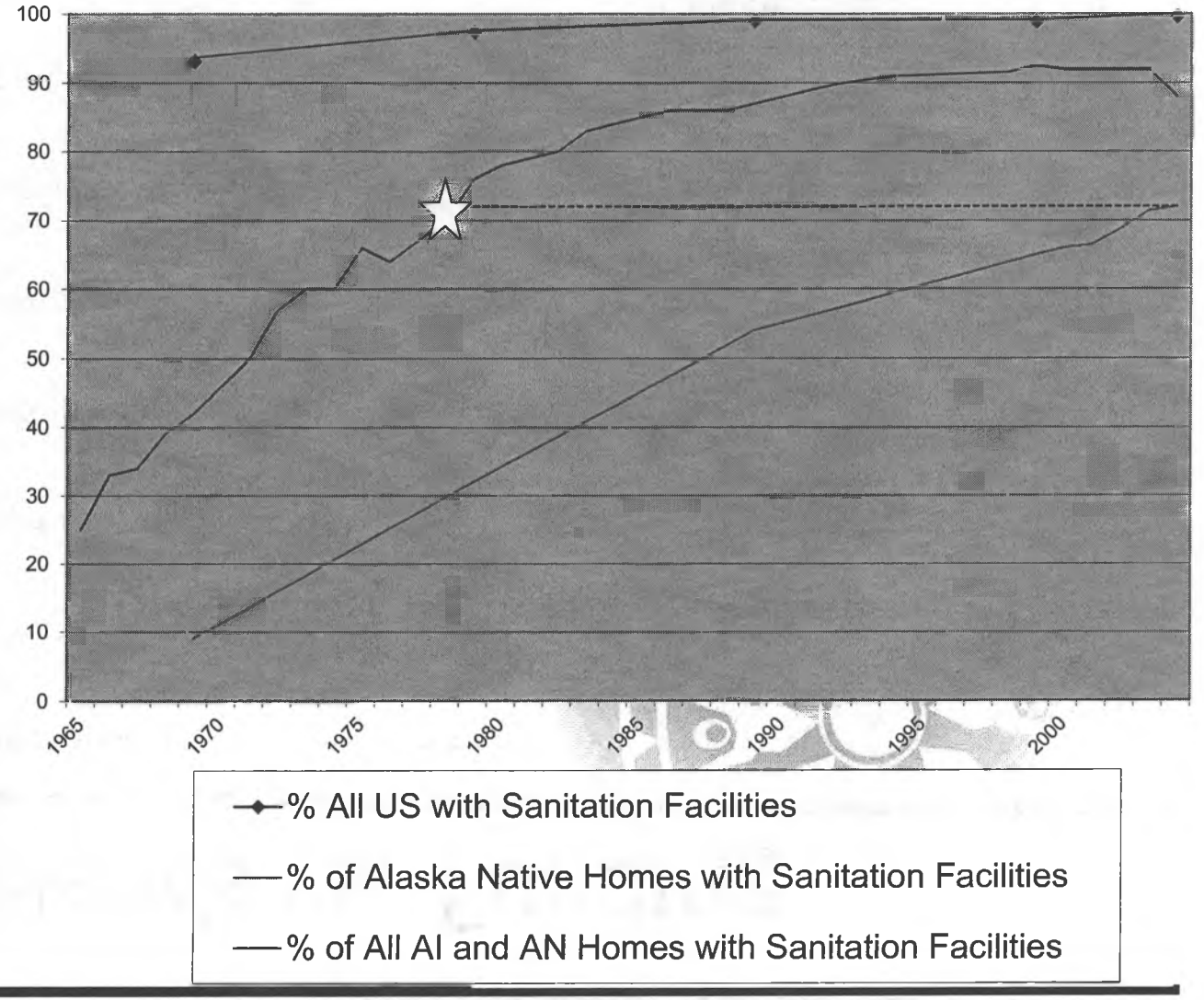
*Data provided by the State of Alaska

Needs vs. Funding



*Data provided by the State of Alaska

Alaska: A Generation Behind



Focus for Future Efforts

- Maintain or Increase Sanitation Funding
- Research and Development for innovative and/or decentralized sanitation systems
- Long Term Sustainability
  - Alternative energy and energy efficiency
  - Operations and maintenance - ARUC

Focus for future Efforts

- How do we serve un-served communities?
- Research and Development
  - Innovative Water and Sewer Systems
  - Necessary Volume of Water to Improve Public Health
  - Arctic Research Commission Efforts

Long Term Sustainability

- Sustainability of Existing Systems
  - Energy Efficiency
    - Audits of Existing Systems
  - Alternative Energy
    - Biomass/Wind
    - Waste Heat
  - Improved Operations and Maintenance
    - Alaska Rural Utility Collaborative (ARUC)
    - Remote Monitoring

Summary

- Sanitation facilities have a positive impact on health
- DEHE provides public health services
- Significant gains have been made
- Federal funding is dropping and not keeping up with needs
- Future focus – Access and Sustainability

A Healthy Future for Rural Alaska

Contact:

Matthew Dixon, P.E.
Vice President of Operations
Division of Environmental Health and Engineering/ANTHC

907-729-3535

mdixon@anthc.org

2011

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ANNUAL REPORT

OUR VISION

Alaska Natives are the healthiest people in the world

OUR MISSION

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

OUR VALUES

Achieving Excellence
Native Self-Determination
Treat with Respect and Integrity
Health and Wellness
Compassion

CONTENTS

ANTHC HISTORY

Alaska Natives are the healthiest people in the world. It's not only an ambitious statement — it's the vision of the Alaska Native Tribal Health Consortium (ANTHC). The inspiration for that vision, and the foundation for achieving it, were set long before ANTHC was formed.

In the 1800s and early 1900s, infectious diseases such as influenza, smallpox and tuberculosis caused deadly epidemics among Alaska Natives. As late as 1950, Alaska Natives had a life expectancy of just 47 years.

In 1953, the Indian Health Service (IHS) opened the Anchorage Medical Center of the Alaska Native Service (ANS existed for one year; the facility was renamed the Alaska Native Medical Center) in downtown Anchorage. It served as a TB sanitarium until the epidemic ceased, then became an acute, specialty and outpatient medical center.

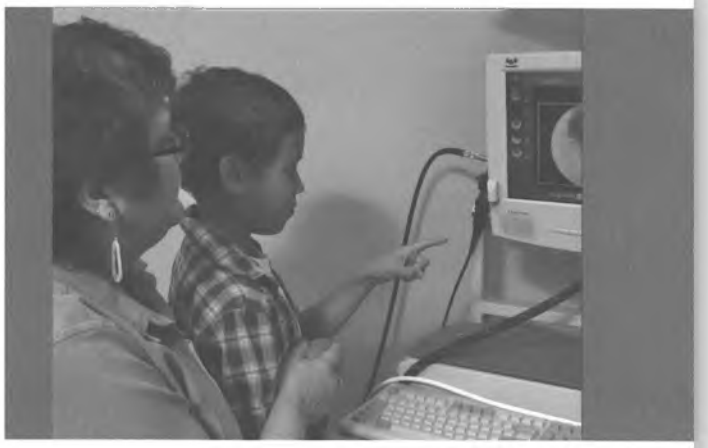
The Indian Self-Determination and Education Assistance Act of 1976 facilitated the transfer of health programs from federal to Native ownership over 25 years. The IHS operated six hospitals and maintained a presence in 160 village clinics through the Alaska Community Health Aide Program (CHAP) until 1975, when regional Alaska Tribal Health Organizations took over the administration of the hospitals and CHAP. Regional Health Organizations developed throughout Alaska. In 1994, self-governance legislation provided for perpetual compact agreements between the U.S. Department of Health and Human Services and tribal programs.

In June 1998, a new era of statewide management of tribal health services began when the Alaska Area Native Health Service signed a contract transferring statewide services to ANTHC.

To achieve the vision that Alaska Natives are the healthiest people in the world, ANTHC works with customers, members of the Alaska Tribal Health System, and non-Native agencies that share common objectives. ANTHC asks employees to provide the highest quality health services and encourages Alaska Natives to make healthy choices and to help keep families and communities strong. ANTHC also works with many partners, lawmakers, volunteers and advocates toward building a unified health system to achieve the highest quality services.

Today, with more than 2,000 staff members providing an array of health services, ANTHC is closer to its vision than ever before, and making a life-changing difference in the health of Alaska Natives every day.

ANTHC INTRODUCTION



Managed and operated by its customers, who are represented by 15 Alaska Native leaders from around the state, the Alaska Native Tribal Health Consortium (ANTHC) is a not-for-profit tribal health organization that provides statewide services in specialty medical care; construction of water, sanitation and health facilities; community health and research; information technology; and professional recruiting. As a member of the Alaska Native Health Board, ANTHC works closely with the National Indian Health Board to address Alaska Native and American Indian health issues.

ANTHC 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. ANTHC employees strive to be our customers' first choice by exceeding expectations in a culturally respectful and positive manner.

LETTER FROM THE CHAIRMAN

GREETINGS,

The past year was one of the most important and inspiring in ANTHC's history. Every day, ANTHC employees took lifesaving and life-changing actions that made a significant positive impact on the health of Alaska Natives in every corner of our state — from providing world-class medical care at ANMC to making better health a part of their daily lives through our public health, construction and prevention work. And we grew as a company, expanding and improving our services to maximize the difference we can make in the future.

Our growth has occurred over 13 years of operating as a consortium, but the source of our success is much deeper. It comes from decades of fighting for self-governance and taking responsibility for our own health and the Alaska Tribal Health System. It's a result of the support and collaboration of the ATHS and consortium members. It's a reflection of the drive and dedication of more than 2,000 hardworking and innovative ANTHC employees. And it's a statement about the countless partners and advocates who work tirelessly with us each day.

We're becoming evermore efficient and effective in our work, yet we still face unique and monumental challenges in delivering the best health care to 140,000 Alaska Natives. With a vision and responsibility as immense as ours, ANTHC simply can't do it alone. We offer roles for everyone — legislators, lawmakers, leaders, patients and Native communities, and all Alaskans. You can become a donor and volunteer with the Healthy Alaska Natives Foundation. You can ensure you and your family members take advantage of preventive services. You can use your vote, voice and influence to advocate for greater state and federal funding and to help build a stronger tribal health system. You can be a part of a success that's much bigger than you and much bigger than ANTHC. It's Alaska's success and the heartbeat of the Alaska Native People.

Thank you all for your work and commitment in the past year. I look forward to celebrating more successes with you in the coming year.

Sincerely,

Andy Teuber
Chairman and President

BOARD OF DIRECTORS

Andy Teuber
ANTHC Chairman and President
KODIAK AREA
NATIVE ASSOCIATION

Charles Clement
ANTHC Treasurer
SOUTHCENTRAL FOUNDATION

H. Sally Smith
BRISTOL BAY AREA
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Mt. Sanford Tribal Consortium

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ASSOCIATION

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CHUGACHMIUT
Native Village of Eyak

Linda Clement
METLAKATLA INDIAN COMMUNITY

Chief Gary Harrison
UNAFFILIATED TRIBES
Chickaloon Native Village

Emily Hughes
ANTHC Secretary
NORTON SOUND
HEALTH CORPORATION

Bernice Kaigelak
ARCTIC SLOPE
NATIVE ASSOCIATION

Charlene Nollner
COPPER RIVER
NATIVE ASSOCIATION

Lincoln A. Bean, Sr.
SOUTHEAST ALASKA REGIONAL
HEALTH CONSORTIUM

Ray Alstrom
YUKON KUSKOKWIM HEALTH
CORPORATION

ALASKA NATIVE MEDICAL CENTER (ANMC)

ANTHC's largest division, ANMC operates a state-of-the-art, 150-bed facility that provides comprehensive medical services to Alaska Natives and American Indians. ANMC is Alaska's only Level II Trauma Center, has received Magnet Recognition for nursing excellence, and recently received the Commitment to Quality Award from Mountain-Pacific Quality Health. ANTHC and Southcentral Foundation jointly own and manage the Alaska Native Medical Center 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.

1997

IHS opens the new Alaska Native Medical Center (ANMC) on Tudor Road in Anchorage.

The U.S. Congress creates the Alaska Native Tribal Health Consortium (ANTHC) under Appropriations Legislation, Section 325 (Public Law 105-83), and ANTHC incorporates as a not-for-profit organization.

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

1998

On June 1, a new era of statewide management of tribal health services began when the Alaska Area Native Health Service signed a contract with IHS transferring statewide services to ANTHC.

ANTHC hires its first employee, Chief Executive Officer Paul Sherry.

ANTHC's Division of Environmental Health and Engineering (DEHE) works to provide services to some of the 62.8 percent of homes throughout rural Alaska that lack water and sewer service.

ANMC IN 2011

On October 1, ANMC launched its Electronic Health Records (EHR) system to improve the quality of patient care. Now medical history, treatment records and medication information are located in one place, providing better patient care coordination with health care providers and instant access to patient health information.

ANMC installed Alaska's only 64-slice low dose radiation CT scanner. This new technology reduces patient radiation exposure by 40 percent, improving patient safety. Other imaging technology upgrades included a new 16-slice CT scanner and MRI machine.

Oncology continued increasing its services by expanding from two to six exam rooms and from eight to 10 infusion chairs. The increased treatment area means more providers — a new medicial oncologist and advance nurse practitioner joined the team this year — to improve patient access.

Maternal Child Health at ANMC plays an integral role in improving the health care delivery system for pregnant women and newborns in Alaska. Today, Alaska has the lowest neonatal mortality rate in the country — our state has gone from 8.3 deaths per 1,000 live births in the early 1980s to 2.27 deaths per 1,000 live births for infants born in 2008. Maternal Child Health also continued improving services by adding four private mother baby rooms and expanding the Neonatal Intensive Care Unit capacity by 50 percent.

1999

ANTHC becomes the largest tribal self-governance organization in the U.S.

Alaska Natives are recruited for engineering externships, with assignments in Bethel, Sitka and Dillingham.

ANTHC and Southcentral Foundation assume joint management of ANMC.

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.

The statewide telehealth project Alaska Federal Health Care Access Network (AFHCAN) begins, allowing clinicians statewide to share data for diagnosis and treatment.

ANMC earns certification as Alaska's only Level II Trauma Center, the highest rating available in Alaska for emergency treatment providers.

DIVISION OF **COMMUNITY HEALTH SERVICES** (DCHS)

DCHS works to elevate the health status of Alaska Native communities while monitoring and improving Alaska Native health through research, training health care providers, and providing education for prevention. DCHS staff studies trends and develops solutions for priority health problems and works with many tribal health organizations and communities to improve the health of Alaska Native families.

DEHE works on design and construction of sanitation facilities in more than 70 communities.

2000

ANTHC 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.

An internship program begins to encourage Alaska Native and American Indian high school, undergraduate and graduate students to enter health fields.

Inform and Inspire, a statewide personal health and wellness campaign, begins on radio, TV and print advertising in Alaska with the message, "Alaska Natives Making Healthy Choices."

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

DCHS IN 2011

- Healthy Village Environments program provided more than $100,000 to five communities to work on air quality, solid waste, sanitation and alternative energy projects that impact human health and the environment, and provided five training sessions to help other communities address serious environmental health risks.
- Colorectal Cancer team helped increase screening rates around the state to combat the leading cause of new cases of cancer in Alaska Native people.
- Injury Prevention program brought its popular white float coat project to eight villages and 16 whaling crews, providing 96 jackets and 24 bib overalls.
- Epicenter staff collaborated with the State of Alaska on "Results and Recommendations Report on Suicide in Alaska," completed the "Alaska Native Mortality Update: 2004-2008," and continued developing a 40-year report on cancer in Alaska Native people.
- Food Distribution Program expanded to 19 villages and produced a nutrition education DVD that focused on the importance of traditional foods.
- Community Health Aide Program offered 10 training sessions for 50 students and five clinical preceptorships.
- The Behavioral Health Aide Program has 73 certified Behavioral Health Aides (BHAs) working around Alaska. This includes 27 BHAs operating at a practitioner level, which accounts for 57 percent of Alaska's BHA practitioners.

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

Dental Health Aide Therapist (DHAT) program begins to increase dental care services in rural villages.

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

A Stop the Pop campaign launches, using letters to schools and stores, support of legislation, and advertising to reduce soda pop consumption and sales in schools.

Several ANMC remodeling projects are completed, including the day surgery area, the addition of an operating room, renovation of the laboratory, and expanded guest areas in Quyana House.

2001

ANTHC 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 Office of Alaska Native Health Research opens to study priority issues of Alaska Native health and train researchers.

CONSORTIUM BUSINESS SUPPORT SERVICES (CBSS)

ANTHC's CBSS division works to help all ANTHC staff work better. CBSS is home to a wide range of departments essential to ANTHC's success: Finance, the Business Resource Center, Contracting and Procurement, Facilities Planning, the Regional Supply Service Center, Health Information and Technology, Human Resources, Marketing and Communications, Risk Management, Legal and Intergovernmental Affairs, Health Systems Networking and Quality Integration and Planning.

ANTHC raises $4 million in grants to provide training for village-based dental health aides, counseling and home health care for elders.

2002

DHATs travel to New Zealand for the best and most cost-effective program training available. ANTHC obtains grant to train village-based DHATs.

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

DEHE creates the Statewide 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.

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

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

CBSS IN 2011

- ANTHC's AFHCAN program reached 100,000 telehealth cases within the Alaska Tribal Health System. AFHCAN has improved health care for Alaska Natives and Alaskans, helped make patient care more efficient, and saves Alaskans and the Tribal Health System more than $6 million annually.
- Human Resources reports that 36 percent of ANTHC's direct hire workforce is Indian Preference and the group continues to raise awareness of ANTHC's commitment to Alaska Native hire.
- Marketing and Communications partnered with the Alaska Association of Student Governments to sponsor a Suicide Prevention Media Contest, which engaged teens around the state to channel their creativity and encourage their peers to make healthy choices. The contest featured powerful messages and increased awareness and education about Alaska's suicide crisis hotline, Careline.
- ANTHC broke ground on its new Healthy Communities Building, which will help the company align our employees, expertise and strength, while standing as a symbol of our statewide work.
- FY11 ended with the introduction of ANTHC's new CEO, Roald Helgesen.

ANMC achieves prestigious Magnet Status for nursing excellence, an honor achieved by only 1 percent of U.S. hospitals.

2003

College of American Pathologists reviews ANMC laboratories and honors it for being in the top 3 percent of laboratories nationally.

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 helps save a woman who is hemorrhaging and could not be transported to an operating room because heavy fog prohibited air travel.

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

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

DIVISION OF **ENVIRONMENTAL HEALTH AND ENGINEERING** (DEHE)

DEHE provides planning, design, construction and operations support of public health infrastructure in Alaska Native communities. Through that work, DEHE offers sustainable public health solutions to communities across our state and protects the health of Alaska Natives.

2004

ANTHC is one of 30 tribal partners to sign Memoranda of Agreement to pursue common interests as members of the Alaska Tribal Health System.

DCHS provides personal care attendant and certified nursing assistant training to 60 students in Bethel and Nome.

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

DCHS's 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.

DEHE starts a construction training program that teaches lifelong skills and provides Alaska Natives opportunities for advancement.

Internship program provides 10 Native undergraduate and graduate students the opportunity to work with DEHE staff.

New ANTHC office building opens.

DEHE IN 2011

- DEHE teams worked on 48 sanitation projects in 36 communities during 2011, including the completion of a three-year project in Pitkas Point, near Saint Mary's in Western Alaska, where local crews constructed a water treatment plant, a sewer system, a washeteria and plumbing to serve all homes.
- DEHE conducted energy audits of tribal buildings in 41 communities, with a special emphasis on water and sewer systems. The Selawik audit found that $175,000 in energy could be saved annually with the implementation of 14 conservation measures; DEHE also identified funding to proceed with those measures.
- Alaska Native hire fuels DEHE's Construction workforce. In 2011, Alaska Natives comprised 92 percent of DEHE's local workforce. Meanwhile, 118 of 123 DEHE's ARUC employees were Alaska Native.
- Alaska Native people suffer from among the highest rates of respiratory disease ever documented. DEHE's Environmental Health program is addressing this disparity by reducing exposure to harmful air pollutants in rural homes with Alaska Native children who have chronic respiratory conditions. This work is made possible by a $1.2 million grant from the Commission for Environmental Cooperation.
- DEHE's Alaska Rural Utility Collaborative (ARUC) now provides utility management services to more than 1,500 homes in 23 communities. ARUC helps communities maintain and improve their current infrastructure and maximize the public health benefits that water and sanitation services provide.

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

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

2005

DCHS 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.

DCHS provides basic Health Aide training for 60 students.

DCHS develops training and certification standards for Behavioral Health Aides.

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

HEALTHY ALASKA NATIVES FOUNDATION (HANF)

ANTHC's charitable arm, HANF works with donors and volunteers to help address a variety of health issues in the Alaska Native community. With the Foundation's guidance, donors can provide the resources and tools necessary to achieve individual and community health objectives in three primary initiatives: health care improvements, wellness and prevention, and healthy village environments.

DEHE improves water and sanitation services in 1,012 homes and works on active projects in 160 communities throughout Alaska.

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

DCHS processes 292 Community Health Aide/Practitioner (CHAP) and Dental Health Aide certification applications for the CHAP Certification Board.

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.

HANF IN 2011

In 2011, the Foundation made $147,000 in donations to ANTHC programs that improve the health and well-being of Alaska Natives, including directing major gifts to impact the health of Alaska's children.

HANF offers sincere and abundant thanks to the distinguished donors who make it all possible:

Founder's Circle ($15,000 and above): Anchorage Valley & Radiation Therapy Centers of Alaska; Neeser Construction, Inc.; Independent Pilots Association (IPA) Foundation.

Visionaries Circle ($7,500 to $14,999): Arctic Slope Regional Corporation; Exxon Mobil; GCI Connect MD; Wells Fargo Bank, Alaska.

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For a listing of all donors and to learn more about HANF, please visit **www.inspiringgoodhealth.org.**

2007

ANTHC launches the Healthy Alaska Natives Foundation (HANF), which identifies initiatives to sustain and inspire a healthy Alaska Native community: health care improvement, wellness and prevention, and healthy village environments.

The 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 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.

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

ANMC receives the Hospital Quality Achievement award from Mountain-Pacific, a Quality Improvement Organization designated by the U.S. Centers for Medicare and Medicaid Services.

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.

DENTAL HEALTH AIDE THERAPIST (DHAT) PROGRAM

Created in 2000 to respond to rural Alaska's extraordinary unmet need for oral health services, the DHAT program now extends dedicated care to 35,000 Alaskans in rural communities. DHAT was the first training program of its kind in the United States and is a model for other areas of the country, and the world, that are seeking ways to address access to dental care challenges.

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.

ANMC remodels and adds computerized systems to its laboratory to improve efficiency, safety, and patient care.

HANF hosts its first Raven's Ball, a black-tie charity event to raise funds to support cancer care improvement, elder care support, healthy village environments, wellness and prevention, and Alaska Native health professions scholarship.

2008

To support cancer patients and health care providers, ANTHC publishes the Traditional Food Guide for Alaska Native Cancer Survivors.

DHAT IN 2011

- The first independent evaluation of dental therapists with two years of intensive training showed that DHATs provide safe, competent, appropriate care. The evaluation confirmed what prior studies of dental therapists practicing in other countries had already shown: dental therapists provide safe care for underserved populations.
- In 2011, the DHAT program was visited by the U.S. Department of Health & Human Services Secretary Kathleen Sebelius and Centers for Medicare and Medicaid Services Administrator Donald Berwick. The DHAT program was also viewed as a model for five states working to implement similar care models.
- The group of eight pioneering DHATs from Alaska that traveled to New Zealand to begin training in 2003 was recognized for national excellence at the National Indian Health Board Consumer Conference.
- Kathy Balasko, RDH, MS, a manager with the DHAT program in Bethel, was given the Senior Hygiene Clinical Service Award for Excellence by the Indian Health Service.
- A class of seven new Dental Health Aide Therapists graduated in December 2010 and another four was expected to graduate in December 2011.

ANMC receives full accreditation from the Joint Commission, the nationally recognized symbol of quality that reflects a health care organization's commitment to meeting the highest quality performance standards.

2009

For a second time, ANMC receives Magnet designation, the highest possible honor in nursing excellence.

ANTHC receives a financial boost of more than $61 million from the American Recovery and Reinvestment Act, including nearly $42 million for statewide water and sewer sanitation projects. The act also provided around $20 million to help fund health facilities upgrades around Alaska.

Four DHATs graduate from ANTHC's training program, marking the first class in America's history.

The Centers for Disease Control and Prevention gave $800,000 to ANTHC's Alaska Native Epidemiology Center to enhance colorectal cancer screening efforts for Alaska Natives, who have substantially higher rates of colorectal cancers compared to other ethnic groups.

For the first time, ANTHC managers and supervisors attend the Leadership Development Institute, a quarterly session designed to train and align leaders, improve communication and inspire results around the organization. ANTHC also launches a balanced scorecard to translate strategy into measurable objectives that drive behavior and performance.

THE FUTURE

ANTHC and our tribal health partners have shown remarkable innovation in providing health care in the most challenging of environments with very limited resources. ANTHC has proven to be an excellent steward of health resources by efficiently and effectively administering programs of the federal government. The investment of resources in ANTHC has provided, and will continue to provide, excellent returns, as shown by the improvement in the health status of American Indians and Alaska Natives living in Alaska.

2010

The passage of the Indian Health Care Improvement Reauthorization and Extension Act better positioned ANTHC and its Behavioral Health and Rural Services to help confront issues like methamphetamine use, suicide and other critical needs.

Vaccination program virtually eliminates hepatitis A infections around Alaska and reduced the rates of the disease among Alaska Native people from among the highest in the U.S. to the lowest.

HANF distributed more than $150,000 to fund mobile dental and ultrasound equipment, cancer care support, prevention outreach for methamphetamine use and suicide, and more.

AFHCAN equipped three major IHS medical centers with telehealth systems that allow providers to care for and consult with patients in outlying areas.

ANTHC'S FY12

Federal Priorities include:

- Requesting $2.5 million for Dental Health Aide Therapist training program as an Oral Health Center of Excellence.
- Requesting $3.1 million to replace outdated medical equipment at ANMC.
- Supporting legislation that would authorize a Title VI self-governance demonstration project allowing tribes and tribal organizations to include non-IHS programs of HHS in their self-governance agreements.
- Requesting $5 million to fund implementation of an Electronic Health Record at ANMC.
- Ensuring that Alaska sanitation facilities programs receive funding at no less than current levels.
- Increasing funding for IHS Contract Support Costs (CSC) by $75 million in FY12 and the following two fiscal years to bring CSC funding up to 100 percent of the federal government's obligation to tribes by FY14.

ANMC received the 2010 Commitment to Quality Award from Mountain-Pacific Quality Health for achieving excellent performance with the quality measures reported to the Center for Medicare Services.

Wellness and Prevention Department's Health Promotion/Disease Prevention Program began creating an action-oriented curriculum to address childhood obesity that focuses on nutrition and physical activity.

Legal and Intergovernmental Affairs supported the successful passage of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, which permanently reauthorizes Indian health programs and enhances ANTHC's ability to improve and expand health care services in rural Alaska.

ANTHC
BY THE NUMBERS FY11

9,147 INPATIENT ADMISSIONS AT ANMC

383,317 OUTPATIENT ADMISSIONS AT ANMC

48 SANITATION PROJECTS IN 36 COMMUNITIES
WORKED ON BY **DEHE** STAFF

41 COMMUNITIES WITH TRIBAL BUILDINGS THAT RECEIVED ENERGY AUDITS

50 COMMUNITY HEALTH AIDES TRAINED

1,586 PEOPLE SERVED AND 111,816 POUNDS OF FOOD SHIPPED BY ANTHC'S FOOD DISTRIBUTION PROGRAM

204 PHYSICIANS AND 443 MAGNET NURSES AT ANMC

5 STATES CONSIDERING THE **ALASKA MODEL** OF DENTAL HEALTH AIDE THERAPIST PROGRAM

92% OF **DEHE'S** LOCAL WORKFORCE IN RURAL COMMUNITIES ARE **ALASKA NATIVES**

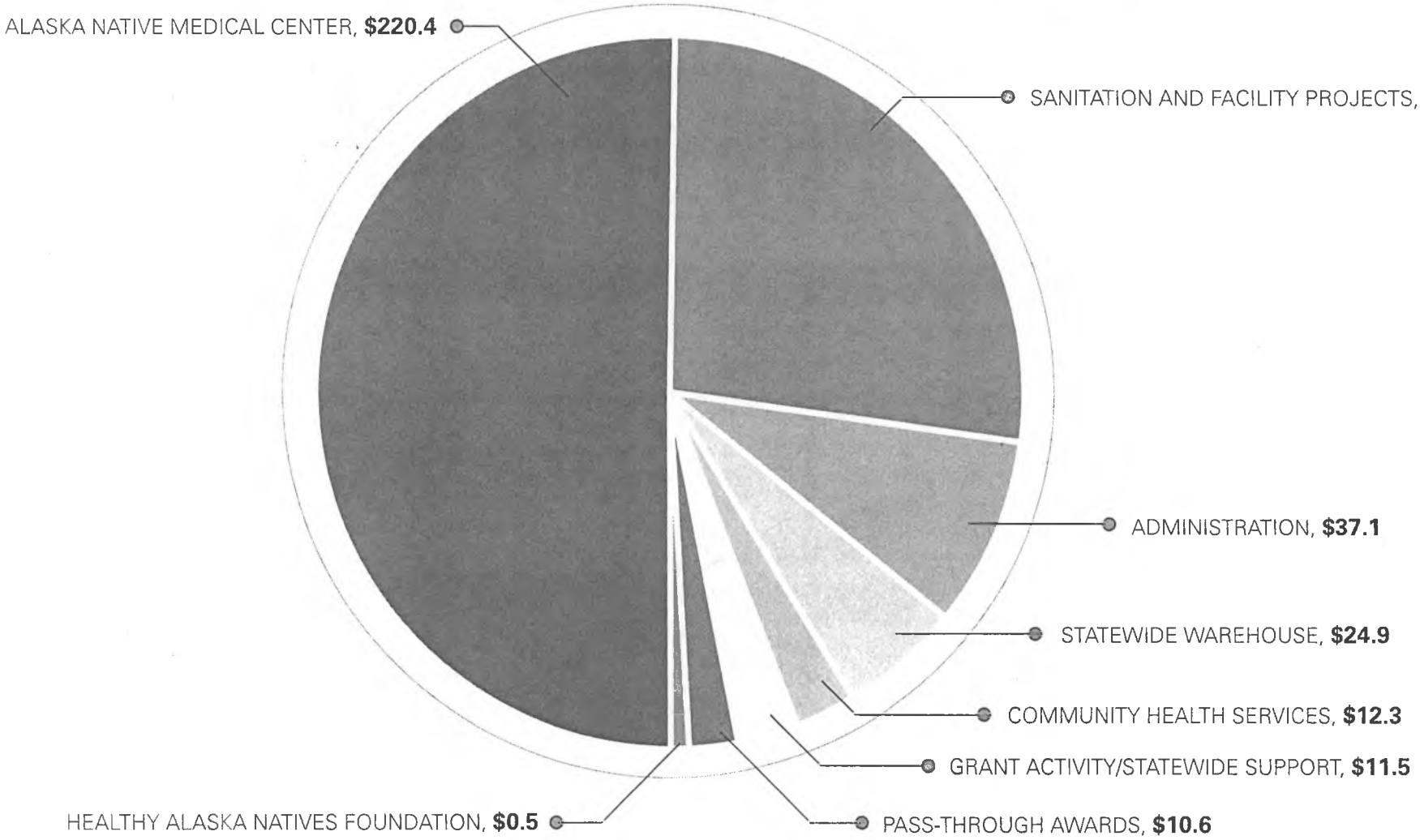
792 USERS AROUND **ALASKA** TRAINED TO USE **AFHCAN** TELEHEALTH EQUIPMENT

1,550 BABIES BORN AT ANMC

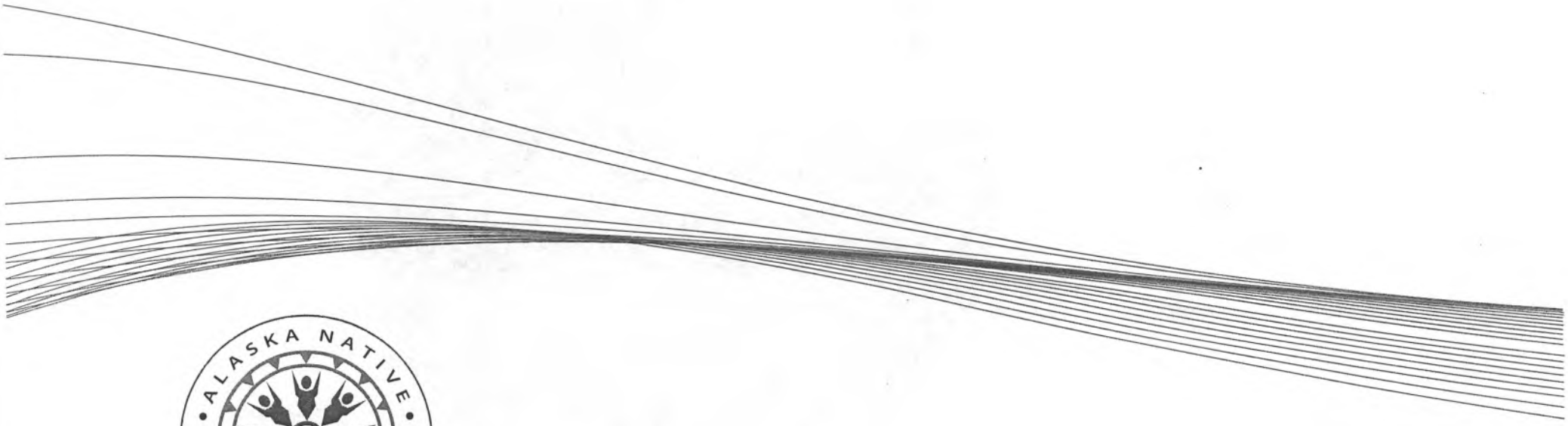
1,300 PEOPLE TRAINED IN APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

ANTHC

FY11 BUDGET (IN MILLIONS)



TOTAL: $436.3 MILLION



ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
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Race, Ethnicity, and Culture:
Are they the same thing?

Race is defined in many different ways, which may lead to confusion sometimes. Actually race is a classification process used to categorize people into groups. In the United states, racial groups have commonly been identified as:

- Caucasian/White
- African-American/Black
- Asian/Pacific Islander
- Alaska Native or American Indian

So if a person is identifying as Alaska Native or American Indian, they are describing themselves within a racial group.

Ethnicity is more commonly defined as subdivisions of racial groups. An ethnic group is a group of people whose members identify with each other, through a common heritage, consisting of a common language, a common culture (often including a shared religion) and a tradition of common ancestry (corresponding to a specific tribe or social unit).

Culture is defined in many different ways but all of the definitions center around "a way of life" such as beliefs, customs, values, attitudes, experiences, social forms, knowledge, and history among other things.

Knowing Who You Are (KWYA)

KWYA is a process for helping workers understand racial and ethnic identity, while giving them some skills/activities to do with others on their own racial and ethnic identity journey, while they are on their own racial and ethnic journey.

KWYA is a 3-part process that includes watching a video (about 20 minutes long), completing an e-learning tutorial on-line (approximately 6 hours long), and then participating in a 2-day workshop.

KWYA workshops are being offered to tribal workers, state workers, and community partners.

KWYA is a required training for all OCS employees. Professionals come together to work on their own journeys about knowing their own Racial & Ethnic Identity (REI), while learning skills to assist youth, families, and caretakers on their own REI journeys.

For further information, please visit the website:
Knowing Who You Are on the Casey Family Programs

http://www.casey.org/Resources/Initiatives/KnowingWhoYouAre/

http://www.hss.state.ak.us/ocs/ICWA/

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Christy Lawton, Director
Office of Children's Services

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INDIAN CHILD WELFARE

Desk Guide to the ICWA Law & Culture

Indian Child Welfare Act

(ICWA, 25 U.S.C., Par. 1902.3)

ICWA stands for the Indian Child Welfare Act, which is a federal law passed in 1978. ICWA was passed in response to the alarmingly high number of Indian children being removed from their homes by both public and private agencies. The intent of Congress under ICWA was to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families" (25 U.S.C. § 1902). ICWA sets federal requirements that apply to state child custody proceedings involving a child who is either: 1) a member of a tribe; or 2) eligible for membership in a tribe, and one of the child's parents is a member of the tribe.

What Does ICWA do?

Declaring there is no resource more vital to the continued existence and integrity of Native American tribes than their children, ICWA:

- Reaffirms the jurisdiction and authority of tribal courts in Native child welfare matters.
- Requires notification of the tribes during involuntary custody proceedings in state courts and establishes the tribes' right to intervene.
- Mandates that active efforts are to be made to return Native American children to their families whenever possible.
- Requires clear and convincing evidence that continued parental custody would mean physical or emotional harm to the child.
- Requires the testimony of experts who come from the child's tribe or have substantial experience in Native American child and family services.
- Requires active efforts toward family rehabilitation and reunification be made before termination of parental rights or final placement decisions are made.
- When foster care and adoption placements are necessary, requires placement preferences be given to members of the child's family, tribe, or other Native families.

Placement of Indian children

§ 1915. Placement of Indian children

(a) Adoptive placements; preferences

In any adoptive placement of an Indian child under State law, a preference shall be given, in the absence of good cause to the contrary, to a placement with:

(1) a member of the child's extended family

(2) other members of the Indian child's tribe

(3) other Indian families.

(b) Foster care placements; criteria; preferences

Any child accepted for foster care or pre-adoptive placement shall be placed in the least restrictive setting which most approximates a family and in which his special needs, if any, may be met. The child shall also be placed within reasonable proximity to his or her home, taking into account any special needs of the child. In any foster care or pre-adoptive placement, a preference shall be given, in the absence of good cause to the contrary, to a placement with:

(1) a member of the Indian child's extended family

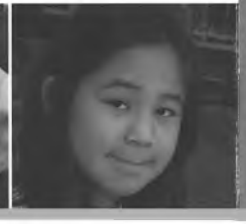
(2) a foster home licensed, approved, or specified by the Indian child's tribe

(3) an Indian foster home licensed or approved by an authorized non-Indian licensing Authority

(4) an institution for children approved by an Indian tribe or operated by an Indian organization which has a program suitable to meet the Indian child's needs.





Questions to ask when trying to determine whether a youth falls under the ICWA laws.

1. Is the child an enrolled member of a tribe?
2. Is either parent an enrolled member of a tribe?
3. Is either parent Alaska Native or American Indian?
4. What are the dates of birth and birthplaces of the parents and grandparents?
5. Are the parents or grandparents affiliated with a particular tribe or village, which may make the child eligible for enrollment?
6. What are the maiden names of the mother and grandmothers?
7. If any of the parents or grandparents were adopted, what were their names before adoption?

CERTIFICATE OF INDIAN BLOOD

The Certificate of Indian Blood (CIB) is a very important document for Native children. The certificate will allow Native children access to Native health, social and other services, which are usually at no cost. All Native children should obtain the certificate. Certificates of Indian Blood are obtained through the BIA for Alaska Native people.

The Office of Children's Services, tribal partners, and community partners are always seeking Native families willing to be caretakers. If a native youth is in state care, we, as partners, recognize the value of that youth being able to be cared for in a native home. If you are interested in becoming a licensed native care provider please contact the number on the back of this brochure.